DDD FOUNDATION, INC.
DENTISTRY FOR THE DEVELOPMENTALLY DISABLED

# *REQUEST FOR MEDICAL CLEARANCE PRIOR TO DENTAL PROCEDURE WITH CONSCIOUS SEDATION*

*The following patient is scheduled to have dental treatment performed under conscious sedation.* ***The patient must be examined by physician within 30 days of proposed procedure.*** *Please fax this form to Dr. Deidra Rondeno at* ***(404) 942-0088*** *or email to* ***frontdesk@dddfoundation.org.*** *Please call* ***(404) 942-0086*** *if you have any questions or require additional information.*

***Patient:*** _____ ***DOB:*** _____

***Proposed procedure:*** _____

***Date of proposed procedure:*** _____

*This patient has been examined by me and is deemed suitable for medical clearance for the above listed procedure under conscious sedation.*

_____
***MD Signature***

_____
***Date***

***Office Phone:*** _____ ***Fax:*** _____

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*For Office Use Only*

***Date:*** _____ ***Time:*** _____ ***ASA:*** *I II III*

*Patient has been reassessed and is an appropriate candidate for Conscious Sedation.*

_____***MD*** _____***DDS***

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| PRE-OPERATIVE MEDICAL HISTORY AND PHYSICAL EXAMINATION | PATIENTS NAME: _____<br>DATE OF BIRTH: ____/____/_____<br>DATE OF PRE-OP EXAM: ____/____/_____ |
|---|---|

← provide date

***** ALL sections of the form MUST be completed*****

## PRE-OPERATIVE MEDICAL HISTORY

Past Medical History: _____

Current Medications: _____

_____

***Is patient taking any form of cannabis? Yes ☐ No ☐ If yes, please list below***

← Check Yes/No

_____

Allergies: _____

## PRE- OPERATIVE PHYSICAL EXAM

| | |
|---|---|
| Chest and Lungs: | Temp: |
| | BP: |
| Cardiovascular: | Pulse: |
| | Resp: |
| Neurological: | Weight: |
| | |
| Gastrointestinal: | |
| | |
| Mental Status: | |
| Pregnancy test: yes ⬭ no ⬭ | Would doctor like blood drawn while patient is sedated? Yes ⬭ No ⬭ |
| | If yes, please fax order/requisition along with diagnosis codes for all labs |

← Check Yes/No

Cleared for Sedation: ⬭ Not cleared: ⬭

**Comments:** _____

***This patient has been examined by me and is deemed suitable for medical clearance for the above listed procedure under conscious sedation.***

_____ _____

**MD SIGNATURE:** **NPI** ***Date:***

Please have MD sign or cosign