INDIO SURGERY CENTER
providing
Children's Dentistry
under General Anesthesia

MEDICAL CLEARANCE FORM:

Patient Name: _____ DOB_____

MD:_____Office Phone:_____FAX#:_____

Past Medical History: _____

Current Diagnosis: _____

Current List of Medications: _____

Ht: _____Wt:_____BMI:_____Hemoglobin:_____

Vaccinations Current: ☐ Yes ☐ No PPD: ☐ Positive ☐ Negative

Current Lab/X-Ray/EKG Results:_____

Surgical History:_____

Please Check Each Area and Describe Abnormalities Below:

*Cardiac**: ☐ WNL ☐ HTN ☐ Murmur ☐ Active ☐ Innocent ☐ VSD (echo required for non-repairs)

☐ Arrhythmia ☐ ASD ☐ Other ***Cardiology consult required**

Respiratory: ☐ WNL ☐ Asthmatic ☐ COPD ☐ Chronic Infections ☐ Snores ☐ Sleep Apnea

☐ Aspiration Precautions ☐ Airway Obstruction ☐ Other

Neuro: ☐ WNL ☐ Seizures ☐ Controlled ☐ Uncontrolled Date of last Seizure: _____

☐ Shunt ☐ Head Injury ☐ Cerebral Palsy ☐ Visual Problems ☐ Other

GI: ☐ WNL ☐ Other *Endocrine:* ☐ WNL ☐ Other *Renal:* ☐ WNL ☐ Other
Hepatic: ☐ WNL ☐ Other *Musculoskeletal:* ☐ WNL ☐ Other

Comments/Notes:_____

_____

_____

_____

Patient is clear for dental surgery to be done under general anesthesia in an outpatient setting.

☐ Yes ☐ No (If not please provide reasoning below:)

_____

_____

_____

_____ _____ _____
MD Name (Print) MD Signature Date

46-900 Monroe Street ◦ Suite B-201 ◦ Indio, CA 92201
(P)760-396-5733 ◦ (f) 760-396-5723 ◦ (e) Info@IndioSurgeryCenter.com