DENTAL SERVICE GROUP

PRE OPERATIVE PHYSICAL

DENTAL TREATMENT UNDER GENERAL ANAESTHESIA / IV SEDATION

General Anaesthesia Performed by a Board Certified Anaesthesiologist

Name ..... D.O.B. / /
First Last D M Y

Dear Physician,
It is proposed that the above named patient will have out-patient dental surgery performed by **Dental Service Group** under general anesthesia or intravenous conscious sedation. Our facility has been inspected and approved as a Non-Hospital Surgical Facility by the College of Physicians and Surgeons of Alberta. We would appreciate your consultation on the form below to help assess the fitness of this patient for anaesthesia. Please notify our office of any significant abnormalities or concerns.

Past Illness and Operations

Cardiac ❑ None
- ❑ Hypertension
- ❑ Cardiac Arrhythmias
- ❑ MI
- ❑ CHF
- ❑ Angina
- ❑ Congenital Heart Disorder

Specify _____

❑ Developmental Delay
Specify _____

Respiratory ❑ None
- ❑ Asthma
- ❑ COPD

Endocrine ❑ None
- ❑ Diabetes
  - ◯ Diet controlled
  - ◯ Oral Hypoglycemics
  - ◯ Insulin controlled
- ❑ Thyroid

GI / GU ❑ None
- ❑ Peptic ulcer
- ❑ Renal failure
- ❑ GE Reflux

Medications ❑ None ❑ See attached

Allergies ❑ None

Pertinent Physical Examination

BP _____ P _____ SaO_2 _____

Weight _____ kg
Height _____ cm
BMI _____

Neck and Head ❑ No significant abnormality

Heart ❑ No significant abnormality

Lungs ❑ No significant abnormality

Abdomen ❑ No significant abnormality

Musculoskeletal ❑ No significant abnormality

Pelvic ❑ No significant abnormality

L.M.P

General Condition and Diagnosis

It is understood that this data is valid on the date of examination, and that the final responsibility for determining fitness for anaesthesia/sedation rest with the attending anesthesiologist on the day of surgery.

Date of Examination ..... Physician Signature .....

Physician Name (Please print) ..... Phone No. .....

IMPORTANT: This form is to be completed and faxed or emailed to the dental office before the day of your operation.

Tel: (780) 413-0824 Fax: (780) 482-0560
email: info@dentalservicegroup.ca

Reviewed with patient on .....
YY / MM / DD

Changes in condition ❑ Yes ❑ No
Describe:

.....
Signature (Dentist/Anaesthetist)

Revised 12/29/17