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. This form should be attached to the patient's History and Physical. ***Patient must be seen within 30 days before dental procedure.*** *Please* ***FAX*** *this form to* ***(404) 942-0088*** *or email to* ***frontdesk@dddfoundation.org****. Please call (404) 942-0086 if you have any questions or require additional information.* ***Forms are due in our office ONE WEEK PRIOR TO APPPOINTMENT.***

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

Proposed procedure: Exam, cleaning, and x-rays. Fillings, sealants, extractions, crowns, root canals, or impressions may be required upon examination.

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.

_____ _____ _____

(please print MD/NP/PA) ***MD/NP/PA Signature*** ***Date***

_____

NPI

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

For Office Use Only

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

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

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

Rev 3/23

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PRE-OPERATIVE MEDICAL HISTORY AND PHYSICAL EXAMINATION	PATIENT'S NAME: _____ DATE OF BIRTH: ____/____/_____ DATE OF PRE-OP EXAM: ____/____/_____

***** 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 **

_____

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.

Comments: _____

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

_____ _____ _____

MD/NP/PA Print *MD/NP/PA SIGNATURE* *DATE*