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Autorización Médica Para Anestesia General Procedimiento Quirúrgico De Bajo Riesgo

Nombre del paciente:	Fecha:
Procedimiento: Examen dental y cirugía bajo anestesia general	
Fecha de la cirugía:	

A quien le interese,

Este paciente solicita tratamiento con anestesia general para una cirugía de bajo riesgo. Complete el formulario de autorización médica adjunto y envíe por fax o escanee el formulario completo de autorización médica y todos los documentos adjuntos (análisis de sangre, electrocardiogramas, etc., según lo recomendado por su médico de cabecera y los especialistas pertinentes) a:

Sleepy Smiles Dental
Teléfono: (301) 778-0411
Fax: (301) 778-0471
Correo Electrónico: info@sleepysmilesdental.com

Los formularios deben completarse COMPLETAMENTE. Los formularios no completados serán devueltos.

Si tiene alguna pregunta o inquietud, no dude en contactarnos.

Saludos,

Sleepy Smiles Dental

Gracias!

History and Physical for Low Risk Surgery under General Anesthesia

PLEASE FILL OUT FORM BELOW COMPLETELY. Forms not completed will be sent back.

Patient Name: _____ DOB: _____ Date: _____

Height MUST be documented in Inches AND Weight MUST be documented in kilograms.

Sex	Race	Age	Height	Weight	Percentile (Pediatrics)	BMI (ADULTS)	BP	Pulse	Resp	Temp
			in.	kg	%		/			

Review of Systems (Check ALL that Apply OR check None)

- | | | | |
|--|---|--|---|
| Cardiovascular: ___ None
___ Congenital Heart dz
___ Hypertension
___ Angina/Chest Pain
___ MI/CAD
___ CHF
___ Arrhythmia/palpitations
___ Pacemaker/AICD
___ Valvular Disease
___ CABG/Cardiac Surgery
___ Coronary Stent
___ Poor Exercise Tolerance
___ PVD
___ Other _____ | Pulmonary: ___ None
___ Asthma/RAD
___ COPD/Emphysema
___ Smoking History
___ SOB
___ Sleep Apnea/Snoring
___ CPAP
___ Cough
___ Wheezing
___ PND/Orthopnea
___ URI
___ Other _____ | Neurological: ___ None
___ TIA or stroke
___ Head Trauma
___ Seizures
___ Cerebrovascular Disease
___ Dementia
___ Osteoarthritis
___ Rheumatoid Arthritis
___ Psychiatric Disorder
___ Neuromuscular Disease
___ Syncope
___ Shunt
___ Other _____ | Gastrointestinal: ___ None
___ Gastroenteritis
___ Hernia; specify _____
___ Constipation
___ Diarrhea
___ Reflux
___ Hepatitis Type _____
___ Cirrhosis
___ Thyroid Disease
___ Recent Steroid Use
___ Obesity
___ Other _____ |
| Hematologic: ___ None
___ Anemia
___ Sickle Cell Disease
___ Sickle Cell Trait
___ G6PD
___ Bleeding Disorder
___ Cancer
___ Chemotherapy
___ Other _____ | Anesthesia Airway: ___ None
___ Family Hx Anesthesia Issues
___ Previous Anesthesia Issues
___ Other _____ | Psychological: ___ None
___ Autism
___ Asperger's
___ PDD or NOS
___ ADHD or ADD
___ Other _____ | Kidney/Renal: ___ None
___ Kidney Disease
___ Recent UTI
___ Other _____ |
| | Pediatrics: ___ None
___ Recent URI/Illness
___ Developmental Delay
___ Prematurity; specify ___ weeks
___ Congenital Anomaly
___ Other _____ | GYN: ___ None
___ Pregnant
___ LMP _____ | Other: ___ None
___ Thyroid Disease
___ Recent Steroid Use
___ Diabetes Type I or II
___ Autoimmune Disorders
___ Eczema
___ Other _____ |

Allergies/RXN (Medication/Seasonal/Foods): _____

Current Medications:

Medication: _____ Dosage: _____ Frequency: _____
 Medication: _____ Dosage: _____ Frequency: _____
 Medication: _____ Dosage: _____ Frequency: _____

Surgical Hx: _____

Most recent Illness: _____ Date of Illness: _____

General Appearance: _____

✓ Check ALL that Apply:

- | | | | | | |
|---|---|---|---|--|--|
| HEENT:
<input type="checkbox"/> No Lymphadenopathy
<input type="checkbox"/> No Sore Throat/Cough
<input type="checkbox"/> No Nasal Congestion
<input type="checkbox"/> EOMI
<input type="checkbox"/> PERRLA
<input type="checkbox"/> Abnormal: _____ | Neurological:
<input type="checkbox"/> DTR Intact and Equal B/L
<input type="checkbox"/> NML Mental Status
<input type="checkbox"/> Abnormal: _____ | Cardiovascular:
<input type="checkbox"/> RRR
<input type="checkbox"/> SIS2
<input type="checkbox"/> Abnormal: _____ | Pulmonary:
<input type="checkbox"/> CTA B/L
<input type="checkbox"/> Abnormal: _____ | Gastrointestinal:
<input type="checkbox"/> Abd Benign-Normoactive BS
<input type="checkbox"/> No Hepatosplenomegaly
<input type="checkbox"/> Abnormal: _____ | Musculoskeletal:
<input type="checkbox"/> NML Muscle Tone
<input type="checkbox"/> NML Strength
<input type="checkbox"/> Abnormal: _____ |
|---|---|---|---|--|--|

I certify I have completed the patient's history and physical. I cleared this patient for General Anesthesia.

Doctor Signature: _____

Date: _____

Doctor Name (Printed): _____

Phone #: _____

Office Name: _____

Fax#: _____