



Dear Physician,

Please provide your expert opinion regarding the patient's cardiovascular fitness to undergo anesthesia for dental surgery.

Return to: info@luxesedation.com or fax at 919-869-2009. Thank you.

PATIENT INFORMATION

Name: _____

Date of Birth: _____

RECENT VITAL SIGNS

Date: _____

Blood Pressure/HR: _____

SpO2: _____

CARDIOVASCULAR CONDITIONS AND TREATMENT

Presenting Conditions: _____

Current Medications: _____

DIAGNOSTICS

Has the patient had any of the following diagnostics?

- ECG No Yes (please attach report)
- ECHO No Yes (please attach report)
- Stress Test No Yes (please attach report)
- Any other tests (_____) No Yes (please attach report)

HIGH RISK CONDITIONS/PRESENTATIONS

Does the patient have any of the following cardiovascular conditions?

- Pulmonary Hypertension EF <= 40% Untreated CAD MI within 12 months
- Heart Block Prolonged QT

AICD/PACEMAKER

- None AICD, Pacemaker, or Both (Please attach the most recent interrogation report)

Underlying Rhythm: _____

Pacemaker Dependent: _____

Pacemaker Mode: _____

Magnetic Action: _____



REVASCULARIZATION PROCEDURES (MOST RECENT ON TOP)

Date	Procedure (balloon, stent, CABG, etc.)	Type (DES, BMS, etc.)	Outcome

ANTICOAGULANT RECOMMENDATIONS

Medication	May Hold?	For how many days?	Comments

PHYSICIAN OPINION AND ATTESTATION

- Does the patient require a further cardiology evaluation at this point? _____
- Possibility of MACE compared to general public: negligible slight moderate significant
- Physician Specialty: Primary Cardiology

Comments: _____

I _____ (physician name/title) attest to the accuracy of the information and the opinion provided herein.

Signature: _____ Date: _____