Medical Clearance Request

Dear Physician,

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

Return to: info@luxesedation.com or fax at 414678467::4. Thank you.

PATIENT INFORMATION

Name: _____ Date of Birth: _____

RECENT VITAL SIGNS

Date: _____ Blood Pressure/HR: _____ SpO2: _____

SPECIALTY CARE

Is the patient under the care of any other medical specialists? ☐ No ☐ Yes (Please list all)

MEDICATIONS AND ALLERGIES

Current Medications: _____

Allergies: _____

SYMPTOMS AND PHYSICAL PRESENTATION

Is the patient experiencing any symptoms? _____

Does the patient have limited exercise tolerance? _____

Does the patient have limited mobility? Please Explain: _____

MEDICAL CONDITIONS

Has the patient had any of the following conditions?

- ☐ Hypertension Signs of end-organ damage: _____
- ☐ CAD/MI Symptoms _____
- ☐ A-Fib Is the rate under control: _____
- ☐ Other Cardiovascular Conditions _____

LUXE ANESTHESIA

Medical Clearance Request

☐ Respiratory Conditions _____

☐ Diabetes Recent HbA1c _____ Date of HbA1c _____

☐ Hyperthyroidism _____

☐ Acromegaly _____

☐ Other Endocrine Disorders _____

☐ Bleeding Disorders _____

☐ Psychologic Disorders _____

☐ Sleep Apnea _____

☐ Genetic Disorders _____

☐ Other Medical Conditions_____

_____

HIGH RISK CONDITIONS

Does the patient have any of the high-risk medical conditions or presentations?

☐ Age >= 80 ☐ Family History of Adverse Reaction to Anesthesia

☐ BMI >= 35 ☐ History of Malignant Hyperthermia

PHYSICIAN OPINION AND ATTESTATION

Is the patient optimized from a medical standpoint? ☐ Optimized ☐ Not Optimized

Does the patient require further medical evaluation? _____

Comments: _____

_____

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

Signature: _____ Date: _____