Medical Clearance Form

Dr._____ Date:_____

Telephone:_____ Fax:_____

Address:_____
_____

Patient:_____ DOB:_____

X:_____
(pt/parent signature for release of medical information)

This is a request for medical clearance on this patient. Please perform the following test in preparation for an outpatient procedure to be done in our office with IV sedation, LMA, or Intubated General Anesthesia (delivered by a CRNA).

___History and Physical, with letter of medical clearance in writing.
___Chem 7
___INR/PT/PTT
___CBC/HCT
___12 lead EKG
___HCG (pregnancy test for female patients of childbearing age, other than those having had tubal ligation or hysterectomy)
___Other_____

Please fax the results of these tests as soon as they are completed. We delay the scheduling of these patients until we have received clearance information. If any contraindications are found that would prevent this patient from having this procedure done in an outpatient setting, please inform us of that information, as well as any recommendations on caring for this patient.

Procedure to be performed:_____

Procedure will take approximately:_____

Thank you for your help in management of this patient and we look forward in hearing from you. If you have any questions, please feel free to call.
Phone: 501.771.4631 Fax: 501.771.4682

Sincerely,
Steven Molpus, DDS, PLC
William Alfonso, DDS