Special Smiles

Comprehensive dental care for persons with special needs

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MEDICAL SPECIALIST CLEARANCE / PRE-ANESTHESIA CONSULTATION REQUEST

Patient Name: _____ **Date of Birth**: _____

Special Smiles provides comprehensive oral healthcare for individuals with intellectual, psychological, and/or developmental disabilities who require general anesthesia to safely receive dental care.

Our anesthesia team requests your evaluation of this patient's relevant medical condition(s) and peri-anesthetic risk before the planned dental procedure in our outpatient dental facility.

Please complete this form and return it by FAX or email along with the following:
(FAX: (267) 639-6270 or email: front.desk@specialsmilesltd.com)

- **Most recent office visit notes**
- **Any relevant test results**
- **Current medication list**

Please provide anticoagulant or SBE management, if applicable:

Thank you for your collaboration in supporting the safe care of our mutual patient. Please contact our office if you have questions

I hereby certify that based on my evaluation and knowledge of this patient's condition(s) he/she is medically optimized to undergo dental surgery under general anesthesia in an outpatient setting.

_____ _____
Physician Signature Date

_____
Printed Physician Name & Credentials

_____ _____
Specialty Practice Name / Organization

_____ _____ _____
Phone Fax Email