



IVS MEDICAL FORM

This form must be completed by your physician prior to each surgery and faxed to our office.

Patient _____ Gender _____ Age _____ Date of Birth DD / MM / YY AHC No. _____

Contact Information

Home No. _____ Work No. _____ Cell. No. _____ Email Address _____

Dear Physician: This patient is to be assessed for fitness to undergo Outpatient Dental Surgery with General Anesthetic or IV Sedation. I would appreciate the form below be filled out to assess the patient for this procedure.

Please fill out completely, including labs and actual EKG Tracing per Dr Byron Nalder MD FRCPC 8274-31108

Weight _____ kg Height _____ cm BMI _____ BP _____ Pulse _____ Allergies _____ Medications _____

Medical History

CNS _____ CVS _____ Murmur [] Yes [] No SBE Prophylaxis [] Yes [] No Describe _____ RESPIRATORY _____ GI / GU _____

Prior Surgery

PRIOR ANESTHETIC PROBLEMS Family history of anesthetic problems _____ Post-op nausea _____ Any other relevant family history _____ PATIENTS' ASA CLASSIFICATION [] ASA I ~ Normal, healthy patients [] ASA II ~ Patients with mild systemic disease [] ASA III ~ Patients with severe systemic disease that is limiting but not incapacitating [] ASA IV ~ Patients with severe systemic disease that is a constant threat to life

EKGs ARE REQUIRED ON EVERYONE OVER THE AGE OF 50 YEARS (Actual EKG tracing)

BLOOD WORK: Electrolytes _____ CBC _____ CREAT _____ Other _____ (Lab investigations at MD discretion) Flexion / Extension C-spine on RA patients.

IF ON BLOOD-THINNERS _____ days off before surgery INR require _____ days before surgery

Premedication: If history of hiatus hernia, reflux, diabetes, or if weight greater than 95 kilograms, please prescribe RANITIDINE 150 - 300 mg with a sip of water two hours prior to procedure.

MD's Information: Print Name _____ Clinic Name and Address _____ Telephone No. _____ Fax No. _____ Date _____ Signature _____