Anesthesia Information

Please note:

There are two separate sets of paperwork that must be completed and submitted:

1. One set must be filled out and submitted by the individual requesting the appointment or their caregiver.
2. The other set must be completed and submitted by the individual's Primary Care Provider (PCP).

Purpose:

To provide dental care under anesthesia for patients with advanced dental needs that can be managed by a general dentist.

Pre-Appointment Requirements:

- Physical Evaluation Form:
  - This must include a current weight, height, BMI, and if possible, a set of vitals.
  - Must be completed by the patient's primary care provider within 30 days before the scheduled dental procedure.
- Medical Testing:
  - A CBC and basic metabolic panel may be required by your PCP (completed within 30 days).
  - An EKG is required if the patient is over 45 years old or has a history of cardiac disease (within 3 months).
  - If you are unable to arrange this test and your PCP requires it, please contact the clinic for assistance. Blood work can be collected during sedation if necessary; however, please note that a courier service must be arranged by the PCP or caregiver to transport the samples.
- Medication & Allergy List:
  Include a current medication list and any known allergies with the physical evaluation form.
  Send to: Fax: 801-763-4571 Email: frdp@utah.gov

Day of Appointment:

- Support Persons:
  The patient must be accompanied by two staff or family members who are

familiar with their behavior. These individuals will assist with patient transfer and recovery; they will need to leave the operatory during the procedure.

- Nail:
  Please remove any nail polish and/or artificial nails prior to the visit.
- Fasting Instructions:
  - No food or drink after midnight the night before the appointment.
  - If the appointment is in the afternoon, the patient may have clear liquids (water, broth, juice without pulp, soda, or Jell-O) up to 6 hours before treatment.
- Medications:
  A nurse will call prior to the appointment with instructions on which essential medications should be taken.
  If there has been any change in the patient's health since the physical exam, please inform the nurse immediately.

After the Procedure:

- The patient will be monitored in recovery before being discharged home.
- The patient should rest for the remainder of the day.
- A prescription will be provided for any medications required after treatment.

Emergency Contact:

In case of a medical emergency, call 911 or go to the nearest Emergency Room.

Clinic Contact Information:

For questions or updates, please contact the clinic during business hours:
Monday–Friday, 7:00 AM – 3:30 PM
If there is no answer, please leave a message, and a staff member will return your call as soon as possible. Phone: 801-763-4169, 801-763-4164

Caregiver Questionnaire

Please take time to carefully fill out this questionnaire:

Patient's Name:

Date of Birth:

Address:

City:

State:

Zip:

Home Phone:

Alternate Phone:

Date of Scheduled Treatment:

Dentist:

Have you or a blood relative ever had a bad or unusual reaction to anesthesia? (Circle one):

Yes/No

If yes, please explain:

Current Diagnoses:

Please list all the patients' diagnoses (or attach current list):

Current Medications:

Please list all current medications with dosage and schedule (or attach current list including vitamins, herbs and over the counter):

Are you currently or have you previously taken osteoporosis medication (Fosamax, Actonel, Boniva, Reclast)?

List any allergies to any medication, food, or latex:

List any serious illnesses, accidents, surgeries, or hospitalizations in the last 5 years:

Do you have heart disease, an irregular heartbeat, or have you ever had a heart attack? (Circle one): Yes/No

If yes, circle all that apply:

- Congenital heart defect
- Murmur
- Rheumatic heart disease
- Prosthetic heart valve
- Stent placement
- History of endocarditis
- Pacemaker
- Arrhythmia
- Irregular heartbeat
- Congestive heart failure
- Heart transplant

Do you have a history of any of the following cardiovascular problems? (Circle one): Yes/No

If yes, circle all that apply:

- Chest pain upon exertion
- Shortness of breath
- Shortness of breath upon exertion
- Shortness of breath lying down
- Swelling of ankles
- High blood pressure
- High cholesterol
- Hyperlipidemia
- Stroke and/or TIA
- Recurrent fainting

- History of DVT

Have you had any prior lung diseases or complications? (Circle one): Yes/No

If yes, circle all that apply:

- Bronchitis
- Pneumonia
- Sleep apnea
- Chronic cough
- Chronic sinus disease
- Seasonal allergies

Have you ever smoked cigarettes, cigars, pipes, or used smokeless tobacco? (Circle one): Yes/No

If yes, how many packs per day and years of use?

Do you have asthma or a history of asthma? (Circle one): Yes/No

If yes, when was the last asthma attack?

How severe and how often do the attacks occur?

How often do you use a rescue inhaler?

Do you use an inhaled steroid? Yes/No

Do you use oral inhalant steroids? Yes/No

If yes, how often do you use the oral steroid?

Last usage?

Do you have or have you had in the past, any of the following diseases or conditions? (If yes, circle all that apply)

- Liver disease, Hepatitis, Jaundice
- Kidney disease, Kidney stones, Ureter or bladder disorder, Urinary problems

- Renal Failure
- Stomach ulcer, Hyper-acidity, Reflux, Colitis, Intestinal problems
- Arthritis and/or painful joints or lymph nodes
- Epilepsy, seizures, fainting episodes, migraines, frequent headaches, or other neurological problems
- Spine, neck or severe back injury or pain
- Cancer
- Sexually transmitted infection, HIV, AIDS
- Do you have anemia or blood disorder

Do you have any other medical problems not listed above? Yes/No

If yes, please explain:

I understand that withholding any information about my health could seriously jeopardize my safety. Therefore, I have reviewed the above medical health history carefully and have answered all questions truthfully and to the best of my knowledge. I hereby give permission to Karen Madigan, CRNA to discuss my medical health with other health professionals involved with my care.

Patient Signature: Date:

24 Hours prior to sedation time:

Please inform Featherstone Ridge Dental Clinic if you are experiencing any of the following:

In the past 24 hours, have you had any of the following symptoms?

(Circle all that apply)

- Fever
- Cold or flu-like symptoms
- Cough
- Nausea or vomiting
- Diarrhea

Do you currently have, or have you recently had, any infections? (e.g., tooth, throat, or respiratory infections)? Circle one: Yes/No

If yes to any of these medical issues, please contact the clinic as soon as possible:

Monday – Friday, 7:00 AM – 3:30 PM

Phone: 801-763-4169 or 801-763-4164

To Be Completed by the Patient's Primary Care Physician

Thank you for taking the time to complete this pre-anesthetic History and Physical (H&P). Due to the patients' inability to cooperate or the need for extensive dental treatment, it has been determined that IV general endotracheal anesthesia is required to safely proceed with care. The H&P must be completed within 30 days of the scheduled procedure.

If you require pre-anesthesia labs, please include the following and attach it with this paperwork: CBC, CMP, EKG (if there is a history of cardiac disease or if the patient is over the age of 45)

This patient is scheduled to have general IV endotracheal anesthesia.

Patient's Name:

Date of Birth:

Today's Date:

Date of IVGA Treatment:

History:

Has the patient experienced any of the following? (Please circle all that apply)

- Large Tonsils
- Epilepsy/Seizures
- Shortness of breath
- Asthma
- Exposure to smoking
- Exposure to vaping
- Alcohol Abuse

- Substance Use
- Allergies
- Diabetes/Hypoglycemia
- Heart Murmur
- Heart Disease
- Pulmonary Disease
- Heartburn/GERD
- History of cold sores
- Hematologic Abnormalities
- Previous Surgery:
- Surgical Complications:
- Other Conditions:
- Family history of bleeding, muscle disease, or anesthesia complications:
- Patient risk of a DVT or PE: Low Medium High Highest

(Please be aware that intermittent pneumatic compression devices will be placed while patient is undergoing procedure)

Immunizations are up to date: Yes/No

Please explain any abnormalities:

Physical Examination

Please note: (If baseline vitals are not completed prior to the appointment, the individual may be rescheduled or canceled. Additionally, if BMI has not been established beforehand, height and weight will be measured prior to sedation. If the individual's BMI falls outside a reasonably safe range, the procedure may be canceled, and other options will be discussed.

- Blood Pressure:
- Pulse:
- Temperature:
- SAT:
- Height:
- Weight:
- BMI:

Please circle if abnormal, and explain below:

- Mental Status
- Throat
- Lungs
- Abdomen
- Dentition
- Skin
- Eyes
- Ears
- Chest
- Back
- Nose
- Heart
- Neurological

Please explain any abnormalities:

Current Diagnoses: Please list all the patient's diagnoses or attach list:

Current Medications (with dosage and schedule) or attach current list:

Comments or recommendations prior to surgery or attach list:

Should this patient do well under general anesthesia? (Circle one): Yes/No

This patient should not undergo general anesthesia. (Circle one): Yes/No

Dr. or Practitioner (Print):

Office phone:

Signature:

Date:

Please fax the completed Medical Evaluation to Featherstone Dental Clinic at 801-763-4571 or email to FRDP@gmail.com

For any questions, please call 801-763-4169