GATEWAY DENTISTRY GROUP

Pre-Operative Physical Form
Dental Treatment Under General Anesthesia

General Anesthesia performed by a Board-Certified Anesthesiologist.

Dear Physician,

It is proposed that the patient named below will have out-patient dental surgery performed at Gateway Dentistry Group Non-Hospital Surgical Facility under General Anesthetic. We would appreciate your consultation on the form below to help assess the fitness of this patient for anesthesia. Please notify our office of any significant abnormalities or concerns. Please forward pertinent consultations and investigations.

Patient's Name: _____ **Date of Birth:** _____
yyyy/mm/dd

Provincial Health Care Number: _____

Past Illness and Operations: ☐ None Was this patient born prematurely? YES ☐ NO ☐	Allergies: ☐ None
Cardiac: ☐ None ☐ Congenital Heart Disorder Please Specify: _____	Pertinent Physical Examination: Weight_____kg BP:_____ P:_____SpO2:_____% Height:_____cm ☐ > 97% on growth chart
Developmental Delay: ☐ None ☐ ADHD ☐ Autism ☐ Behavioral Disorder ☐ Other:_____	Neck and Head: ☐ No Significant abnormality
Respiratory: ☐ None ☐ Asthma	Heart: ☐ No Significant abnormality
Endocrine: ☐ None ☐ Diabetes ☐ Thyroid	Lungs: ☐ No Significant abnormality
GI/GU: ☐ None ☐ GE Reflux	Abdomen: ☐ No Significant abnormality ☐ Obese
Medications: ☐ None ☐ See Attached	Musculoskeletal: ☐ No Significant abnormality
	General Conditions and Diagnosis:

It is understood that this data is valid on the date of examination and that the final responsibility for determining fitness for General Anesthesia rests with the anesthesiologist on the day of surgery.

Physician Name (please print) _____ **Physician Signature** _____

Date of Examination _____ **Telephone Number** _____

**Pre-operative physical is valid for 90 days after examination.

IMPORTANT: **This form is to be completed and returned to this Facility, by fax, email or brought in, as soon as possible in order to proceed with your dental surgery.**

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