

Patient Last Name:

For SDMC Use Only:

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Part 4. Exams and Tests			
a. Date of most recent annual physical examination. Include a copy of the most recent physical. Date: _____			
b. Abnormal findings from all exams and tests:		<input type="checkbox"/>	N/A
c. Date of most recent EKG. Include a copy. Date: _____		<input type="checkbox"/>	N/A
d. Date of most recent chest x-ray. Include a copy. Date: _____		<input type="checkbox"/>	N/A
e. Date of most recent laboratory tests. Include a copy of the most recent lab work. Date: _____			
Part 5. Additional Information			
a. List any cardiac or pulmonary condition(s):		<input type="checkbox"/>	N/A
b. List any major illness, surgery, and/or hospitalizations in the last year:		<input type="checkbox"/>	N/A
c. List any other known physical conditions or medical diagnoses:		<input type="checkbox"/>	N/A
Part 6. Anesthesia			
Has the patient had general anesthesia before? Intravenous sedation and monitored anesthesia care are not considered general anesthesia for SDMC cases.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Date of most recent anesthesia: Date: _____		<input type="checkbox"/>	N/A
Any history of adverse reactions to general anesthesia? If yes, describe:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

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Part 7. Schedule			
Is the requested procedure(s) scheduled? <input type="checkbox"/> Yes Date: _____ <input type="checkbox"/> No			
If no, what is the anticipated scheduled date? The standard consent period is 60 days from the date of the hearing. Is 60 days sufficient? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If a longer consent is required, please indicate the time frame requested and the reason for the request.			
Consent period being requested:			
<input type="checkbox"/> 90 days	<input type="checkbox"/> 120 days	<input type="checkbox"/> 180 days	<input type="checkbox"/> 365 days
Reason for the request:			
<input type="checkbox"/> Medical	<input type="checkbox"/> Scheduling		
Part 8. Prior SDMC Review			
a. Has the patient been previously reviewed by SDMC? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
b. Date the most recent SDMC approved procedure was performed:			
c. Procedure(s) previously requested:			
d. Results of procedure(s):			
Part 9. Form Submitter's Contact Information			
Print Last Name:		Print First Name:	
Email Address:			
Agency Name: (Please avoid abbreviations)			
Business Address:			
City:		State:	Zip:
Phone: <small>Include area code ()</small>	Ext:	Cell: <small>Include area code ()</small>	Fax: <small>Include area code ()</small>
Part 10. Attestation			
The above information and statements are given to the best of my knowledge, complete and truthful.			
Signature of Form Submitter:		Date:	

PLEASE REMEMBER TO ATTACH

Documentation related to the proposed major medical treatment(s) being requested:

- Consults
- Annual Physical Exam
- Progress notes
- Results of diagnostic tests