



Patient Last Name:

For SDMC Use Only:

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<b>Part 4. Exams and Tests</b>	
a. Date of most recent annual physical examination. <i>Please include a copy of the most recent physical.</i> Date: _____	
b. List any current abnormal test or exam results related to the requested procedure:	N/A
c. Date of most recent EKG. <i>Please include a copy if available.</i> Date: _____	N/A
d. Date of most recent chest x-ray. <i>Please include a copy if available.</i> Date: _____	N/A
e. Date of most recent laboratory tests. Include a copy of the most recent lab work. Date: _____	
<b>Part 5. Additional Information</b>	
a. List any cardiac or pulmonary condition(s):	N/A
b. List any major illness, surgery, and/or hospitalizations in the last year:	N/A
c. List any other known physical conditions or medical diagnoses:	N/A
<b>Part 6. General Anesthesia</b>	
Has the patient had general anesthesia before? <i>(Intravenous sedation and monitored anesthesia care are not considered general anesthesia for SDMC cases.)</i>	
<input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Unknown

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**Part 7. Consent Period Requested**

7. Is the requested procedure(s) scheduled?      Yes Scheduled on: \_\_\_\_\_      No

Length of Time Requested on the Consent:      60 days\*      90 days (see below)      120 days (see below)      180 days (see below)      365 days (see below)

\*The standard SDMC consent expires in 60 (sixty) days.

If a consent period longer than 60 days is needed, please indicate the reason for the request:  
**Medical Need** for longer consent - patient will need long-term treatment or multiple treatments/procedures on this request      **Scheduling-** A longer consent is requested in order to accommodate 60+ days needed to obtain an appointment or complete the procedure/treatment      **Other:**

**Part 8. Prior SDMC Review or Previous Decision-Maker**

Has the patient been previously reviewed by SDMC?      YES      NO\*      Unknown

\*If the patient has not come to SDMC for Consent before, who previously provided consent? (if known)

**Part 9. Form Submitter's Contact Information**

Please Print Last Name: \_\_\_\_\_ Please Print First Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

Agency Name: (Please avoid abbreviations) \_\_\_\_\_

Workplace Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Fax: \_\_\_\_\_ Cell: \_\_\_\_\_  
Include area code      Include area code      Include area code

**Part 10. Attestation**

The above information and statements are given to the best of my knowledge, truthful and accurate.

Signature of Person Submitting the Form: \_\_\_\_\_ Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YEAR

- 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 related to medical request