

UT Southwestern Frisco Orthopaedic Surgery

12500 Dallas Parkway, Frisco, TX 75033

Phone: 469-604-9070 Fax: 469-604-9071

Dental Surgical Clearance Request

Please complete form and fax back to 469-604-9071 as your response is time sensitive

___ Standard Request (10 Business Days)

___ Urgent Request (STAT)

Patient Sticker

To: _____

From: _____ Dr Georges Bounajem _____

Procedure: _____ Procedure Date: _____

Pre-Procedure Requirements: ___ To minimize the complication of an infection post total joint surgery, we like to make sure that the patient is clear of any infections _____

Please Initial Clearance Below

___ Patient is a low risk for surgery from a Dental standpoint. There are no restrictions identified. The patient **IS** clear to proceed as scheduled.

___ Further testing is necessary to gauge the patient's risk for an invasive procedure as the patient is at Prohibitive risk from a Dental standpoint. The patient is **NOT** yet released for the procedure.

___ The patient is at increased risk from a Dental standpoint but is cleared for the procedure with the following recommendations:

1. _____

2. _____

___ I certify that the patient has had a dental exam within the past 6 months and does not have a dental infection requiring treatment.

Physician's Name (Print) _____

Physician's Signature: _____ Date: _____