# 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_____

_____

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*****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: _____