

HOSPITAL CASES 2025

HOSPITAL PROCEDURES WILL BE DONE AT: **CANDLER HOSPITAL, 5353 REYNOLDS STREET, SAVANNAH, GA 31405 (912-819-6000)** – ***Patients UNDER age 3 and Specific Medical Conditions, height/weight, the anesthesiologist will determine which location after reviewing the medical health history***

OR AT THE **SURGICAL SPECIALTY CENTER, PLAZA C, 11909 MCAULEY DR, SAVANNAH, GA 31419 (912-819-4100)**- ***Patients age 3 and OLDER only***

NO FOOD OR DRINK AFTER MIDNIGHT THE NIGHT BEFORE SURGERY

*Please be aware from arrival to dismissal time, you can be there for **4 to 5 hours***

BRING A CHANGE OF CLOTHES!! Sometimes a child may have an accident while under anesthesia.

*I WILL SCHEDULE THE CHILD A CLEARANCE (PRE-OP) FOR DENTAL SURGERY WITH THEIR PEDIATRICIAN WITHIN **30 DAYS OF THE SURGERY**. THE CHILD MUST BE SEEN WITHIN A CERTAIN TIME FRAME OF THE SURGERY DATE. PLEASE DO NOT CHANGE APPTS WITHOUT LETTING ME KNOW.

***WHEN YOU GO TO THE PEDIATRICIAN YOU MUST HAVE THE ATTACHED CLEARANCE FORM FILLED OUT. IT WILL BE YOUR RESPONSIBILITY TO MAKE SURE I RECEIVE THIS FORM BY FAX AND KEEP A COPY FOR YOURSELF. THE HOSPITAL WILL NOT SEE THE PATIENT WITHOUT THIS FORM.**

*THE HOSPITAL REQUIRES A PRESURGICAL SCREENING FOR ALL PATIENTS. THE HOSPITAL WILL CALL YOU ONE TO TWO DAYS BEFORE THE SURGERY. WE MUST ALWAYS HAVE CURRENT PHONE NUMBERS TO REACH YOU!

THE SURGERY LIST MAY TAKE UP TO **6+** MONTHS TO GET AN APPOINTMENT. PLEASE TAKE INTO CONSIDERATION HOW IMPORTANT IT IS TO MAKE AND KEEP THESE APPOINTMENTS.

****IF YOU MISS ANY OF THESE APPOINTMENTS WE WILL NOT RESCHEDULE. ****

NICOLE PROUGH FREDERICKSON

SURGERY COORDINATOR

(912-355-5901 ext. # 4)

DENTISTRY FOR CHILDREN AND ADOLESCENTS, P.C.

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(Phone) 912-355-5901 ext 4 (Fax) 912-355-8861

Email:nicoleprough@comcast.net

DATE: _____ **TIME** _____

NAME: _____ **D.O.B.** _____

WEIGHT: _____ **HEIGHT:** _____

PAST HISTORY

ALLERGIES:

CURRENT MEDICATION:

HEART:

LUNGS:

CLEARED FOR DENTAL SURGERY UNDER **GENERAL ANESTHESIA?** **PLEASE CHECK:** YES _____ NO _____

PHYSICIAN NAME: _____

PHONE NUMBER: _____

PHYSICIAN SIGNATURE: _____

FAX THIS COMPLETED FORM TO NICOLE AT 912-355-8861 or email to nicoleprough@comcast.net. NO SURGERY WILL BE DONE WITHOUT THIS CLEARANCE FORM. *Parents, it is your responsibility to make sure I receive this form, VERY important that you keep a copy, if I do not receive it from the doctor, you can email or text a photo of the form to me.*****