**Tot 2 Teen Dental Care**
**Dr. Anita B Gartner Inc.**
Suite 219 - 179 Davie Street
Vancouver, B.C. V6Z 2Y1 Canada
tot2teendental.com

CHILDREN'S & WOMEN'S HEALTH CENTRE OF BRITISH COLUMBIA

AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

# BCCH
# AUTHORIZATION FOR SURGICAL OPERATION OR DESIGNATED SPECIAL PROCEDURE OR TREATMENT

Re: ______________________________
(NAME OF PATIENT)

With regard to the above-named patient, I, the undersigned do hereby consent to:

A. Treatment with oral rehabilitation
(TREATMENT)

under the direction of Dr. Anita B Gartner DHD ~~M.D./D.D.S.~~

B. The surgical operation or special procedure of Oral examination, cleaning/scaling, fluoride application, x-rays, fissure sealants, white plastic fillings, silver amalgam fillings, stainless steel crowns, pulp treatment, root canal treatment, extractions

under the direction of Dr Anita B Gartner DHD ~~M.D./D.D.S.~~

The nature and anticipated effects of such treatment, surgical operation or special procedure as detailed in A or B above have been explained to me by Dr. Anita B Gartner and I understand the explanation.

I also authorize such additional or alternative treatment, surgical operations or special procedures as, in the opinion of the physician or dentist named in the first paragraph, are immediately necessary.

I further agree that, at his or her discretion, the physician or dentist named in the first paragraph may make use of other surgeons, physicians, dentists and hospital medical staff working under his or her discretion, in the performance of all or part of the surgical operation or special procedure.

I also consent to the administration of anaesthesia and to the use of such anaesthetics as may be deemed advisable by the anaesthetist.

Dated this ____________ day of ______________________ 20 ______

______________________________
Signature of Patient

______________
Date

X______________________________
Signature of Parent or Legal Guardian

______________
Date

______________________________
Witness Name Signature

______________
Date

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# BCCH – Medical/Surgical/Dental Day Care History Form

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SURGERY DATE: ______________

PLEASE FAX TO: 604-224-6211

Patient's name: ______________

Patient's address: ______________

______________

Phone: ______________

Medical Ins. No.: ______________

Proposed Procedure ______________

______________

Significant Medical History ______________

______________

______________

Significant Anaesthetic History ______________

______________

______________

Medications ______________

Allergies ______________

Social/Family History ______________

______________

Physical Examination – List Significant Findings:

______________

E.N.T. ______________

______________

Heart and Lungs ______________

______________

______________

Abdomen ______________

______________

Musculoskeletal ______________

Other Findings ______________

______________

______________

______________

______________

Date ______________ Signed ______________ M.D.

Address ______________

**TO BE COMPLETED FOR MEDICAL/SURGICAL/DENTAL DAY CARE CASES ONLY AND SUBMITTED WITH BOOKING REQUEST AND INFORMED CONSENT**

(CONTINUE OVERLEAF IF NECESSARY)

00055562 - (94782) July/94