Medical Consultation

Name _____ Date _____

Home Address_____City_____State_____ Zip_____

Dear Doctor _____

The above named patient is seeking dental care in our office. In order to provide the best care possible, it is necessary that we know the following information. The patient indicates a history of:

- ❑ Hypertension
- ❑ Cardiovascular Accident
- ❑ Prosthetic Heart Valve
- ❑ Mitral Valve Prolapse
- ❑ Endocarditis
- ❑ Anemia
- ❑ Renal Disease
- ❑ Pulmonary Disease
- ❑ Diabetes
- ❑ Systemic Lupus Eythematous
- ❑ Marfan's Syndrome
- ❑ Chemotheraphy
- ❑ HIV
- ❑ Prescription Diet Drugs

(I.E Pondimin/Phentaramine Combination)

- ❑ Adrenal Insufficiency Or Steroid Therapy
- ❑ Rheumatic Heart Disease
- ❑ Heart Murmur
- ❑ Systemic-Pulmonary Artery Shunt
- ❑ Drug Allergies
- ❑ Hepatitis A Or B (Circle One)
- ❑ Leukemia
- ❑ Renal Dialysis With Shunts
- ❑ Liver Disease
- ❑ Anticoagulant Therapy
- ❑ Prosthetic Joint
- ❑ Radiation Therapy To Head And Neck
- ❑ Pacemaker, Type_____
- ❑ Other _____

Treatment to be performed on this patient includes:

- ❑ Oral Surgical Procedures Including Extractions
- ❑ Dental Radiography
- ❑ Local Anesthetics (Topical And Injectible)
- ❑ Oral Prophylaxis (To Include Some Removal Of Epitheliat Tissue)
- ❑ Deep Scaling And Root Planing
- ❑ Endodontic Treatment (Root Canals)

Possible Considerations Are:

- ❑ Bleeding With Transient Bacteria
- ❑ Prolonged Bleeding
- ❑ Pacemaker Interference Due To Use Of Ultrasonic Scaling Devices
- ❑ Other _____

We are requesting a medical consultation for this patient.
Please indicate appropriate response below.

1. This patients current medications include: _____
2. This patient requires no prophylactic antibiotic premedication regimen for the indicated procedures. Y | N
3. Thisioatient requires prophylactic antibiotic coverage for the prescribed dental procedures. Please indicate regimen if other than standard AHA regimen. _____
4. ❑ This patient may not receive dental treatment at this time.
5. ❑ This patient may receive limited dental treatment at this time.
6. Comments: Please use reverse side.

Date: _____ Physician's Signature_____