MEDICAL CONSULTATION REQUEST

To: Dr. _____

RE: _____

Vital Signs BP: _____ Pulse: _____

Date of Birth _____

Please complete the form below and return it to:

_____

_____

Phone _____

Fax _____

- **Our patient has presented with a history of the following medical problem(s):**
  - ☐ High Blood Pressure ☐ Mitral Valve Prolapse / Rheumatic Heart Disease ☐ Multiple meds. ☐ Diabetes
  - ☐ Recent CVA/Stroke ☐ Cancer treatment ☐ Prosthetic joint replacement ☐ Stent ☐ Other: _____
- **The following treatment is scheduled in our office:**
  - ☐ General Dentistry ☐ Extractions ☐ Gum Surgery ☐ Implant Surgery ☐ Other: _____
- **Most patients experience the following with the above planned procedures:**
  1. Bleeding: ☐ minimal ☐ significant
  2. Stress/Anxiety: ☐ low ☐ medium ☐ high

_____ _____
Dentist Signature Date

■ PHYSICIAN – *PLEASE COMPLETE THIS SECTION*

Please provide any information regarding the above patient's need for antibiotic prophylaxis, current cardiovascular condition, coagulation ability, and the history and status of infectious diseases. Ordinarily, local anesthesia is obtained with agents containing a vasoconstrictor. For some surgical procedures, the vasoconstrictor concentration may be increased to 1:50,000 for hemostasis. The vasoconstrictor dose NEVER exceeds 0.2 mg total.

- **CHECK ALL THAT APPLY**
  - ☐ **OK** to **PROCEED** with dental treatment; **NO** special precautions and **NO** prophylactic antibiotics are needed.
  - ☐ Antibiotic prophylaxis **IS** required for dental treatment according to the current American Heart Association and/or American Academy of Orthopedic Surgeons guidelines.
  - ☐ Other precautions are required (please list): _____
  - ☐ ***DO NOT*** proceed with treatment. (Please give reason): _____
  - ☐ Patient has an infectious disease:
    - ☐ AIDS (please provide current lab results)
    - ☐ TB (PPD+/active)
    - ☐ Hepatitis, type _____, (acute/carrier)
    - ☐ Other (explain) _____
  - ☐ Requested relevant medical and/or laboratory information is attached.
- **Treatment may proceed on** _____(Date)

_____ _____
Physician Signature Date

■ PATIENT CONSENT

I agree to the release of my medical information to the office of the above named dentist.

_____ _____
Patient Signature Date

KEEP A COPY OF THE COMPLETED FORM IN THE PATIENT'S FILE