THE DENTAL CARE CENTER
General Family Dentistry

MEDICAL CONSULTATION REQUEST

To: Dr. _____

_____

_____

RE: _____

_____
Date of Birth

Please complete the form below and return it to

Dr. _____

_____

_____

Phone # _____

Fax # _____

Our patient has presented with the following medical problem(s): _____

_____

_____

The following treatment is scheduled in our clinic: _____

_____

Most patients experience the following with the above planned procedures:

bleeding: ❑ minimal (<50ml) ❑ significant (>50ml)

stress and anxiety: ❑ low ❑ medium ❑ high

Dentist's Signature _____ Date _____

PHYSICIANS RESPONSE

Please provide any information regarding the above patients need for antibiotic prophylaxis, current cardiovascular condition, coagulation ability, and the history and status of infectious diseases. Ordinarily, local anesthesia is obtained with 2% Lidocaine, 1:100,000 epinephrine. For some surgical procedures, the epinephrine concentration may be increased to 1:50,000 for hemostasis. The epinephrine 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) _____

_____

Treatment may proceed on (Date) _____

❑ Requested relevant medical and/or laboratory information is attached.

Physician's Signature _____ Date _____

PATIENT CONSENT

I agree to the release of my medical information to The Dental Care Center.

Patient's Signature _____ Date _____