MEDICAL CONSULTATION REQUEST

To: Dr		Please complete the form below and return it to:
RE:		
Vital Sic	gns: BP:Pulse:	
	-	Phone:
Date of	Birth:	Fax:
 • Our patient has presented with a history of the following medical problem(s): High Blood Pressure Cardiac Disease/Surgery Bisphosphonate Therapy 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 Stress/Anxiety: low medium high 		
PHYSICIAN – PLEASE COMPLETE THIS SECTION Please provide any information regarding the above patient's need for antibiotic prophylaxis, current cardiovascular condition, coagulation		
 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 <u>ALL</u>THAT APPLY OK to <u>PROCEED</u> with dental treatment; <u>NO</u> special precautions and <u>NO</u> prophylactic antibiotics are needed. Antibiotic prophylaxis <u>IS</u> 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:	
		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

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