MEDICAL CONSULTATION REQUEST FOR DENTISTRY

Office Name: **Date:**

Dr. _____ **Office phone #_____**

Subj: **DOB:**

Dr._____, we thank you for your time and request your guidance and input addressing the patient mentioned above which we jointly share.

The patient has presented with the following medical problems and concern:

_____
_____
_____
_____ The patient is scheduled for the following treatment in our office on:
_____
_____
_____Most patients experience the above planned procedures with minimal bleeding, stress and anxiety and under local anesthesia of 2% Lidocaine with 1/100,000 epinephrine.

We would appreciate your guidance regarding any limitations or precautions you feel are important in allowing us to provide our patient with the best quality of care. Conditions needing input include antibiotic prophylaxis, current cardiovascular condition, coagulation status, any interruption ongoing therapy, coordination with other therapeutic therapy (chemo or radiation) and any history and status of infectious diseases.

PLEASE 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)_____
_____

_____

Physician Signature and date

_____

Thank you for your time and assistance with our patient and have a great day.

George E. Eifler, D.D.S., M. S. Prosthodontist.