Medical Clearance

CONFIDENTIAL

Physicians Immediate Reply Requested

Date	Pages
To (Physician's Name)	Sent To (Physician's Fax/Email)
From (Doctor's Name)	Dentist's Phone
Patient's Name	Dentist's Fax/Email
Patient's Date of Birth	Patient's Signature authorizing exchange of information between Dentist and Physician

Subject:

Medical Clearance for Dental Treatment

SECTION 1 To be completed by the **Dentist**	1. Dental Treatment Plan 2. Patient's condition may warrant special considerations 3. If prophylactic antibiotic treatment is required, I will follow the current AHA guidelines and prescribe the following protocol and prescription

SECTION 2 To be completed by the **Physician**	1. Is the patient healthy enough to undergo this treatment? (Please Circle) Yes No 2. Does the patient's medical condition require prophylactic antibiotic treatment? (Please Circle) Yes No 3. If you recommend a different prophylactic plan or antibiotic, please indicate below: _____ _____ _____

Dentist's Signature Date

Physician's Signature Date