MEDICAL CONSULTATION REQUEST

To: Dr._____
_____
_____

RE: _____
_____
Date of Birth

Please complete the form below and return it to
ABC Children's Dentistry
Dr. Jeffrey D. Singer
1001 Laural Oak Road, Suite C-2
Voorhees, NJ 08043
Office: (856) 783 - 3515
Fax: (856) 783 - 3517

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

PHYSICIAN'S RESPONSE
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 2% Lidocaine, 1:100,000 epinephrine or 4% Septocaine, 1:100,000 epinephrine.

*CHECK **ALL** THAT APPLY*

□ **OK** to **PROCEED** with dental treatment; **NO** special precautions and **NO** prophylactic antibiotics are required.

□ 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)_____

□ Patient has an infectious disease:
□ AIDS (please provide current lab results) □ Hepatitis, type _____, (acute/carrier)
□ TB (PPD+/active) □ Other (explain)_____
□ Requested relevant medical and/or laboratory information is attached.

_____ _____
Physician Signature Date

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

_____ _____
Patient Signature Date