

MEDICAL CONSULTATION REQUEST

To: Dr. _____

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

RE: _____

Date of Birth _____

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:
- | | |
|--|---|
| <input type="checkbox"/> AIDS (please provide current lab results) | <input type="checkbox"/> Hepatitis, type _____, (acute/carrier) |
| <input type="checkbox"/> TB (PPD+/active) | <input type="checkbox"/> Other (explain) _____ |
| <input type="checkbox"/> 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