MEDICAL CONSULTATION REQUEST

To: Dr.________________________________________

Please complete the form below and return it to
ABC Children’s Dentistry
Dr. Jeffrey D. Singer
1001 Laurel Oak Road, Suite E-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:
  □ 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 __________________