RAMAPO ORAL AND MAXILLOFACIAL SURGERY, P.C.
180 RAMAPO VALLEY ROAD (ROUTE 202)
OAKLAND, NJ 07436
TEL. 201-337-3797 / FAX. 201-337-8845

PERI-OPERATIVE RECOMMENDATION
REQUEST FOR DENTAL TREATMENT

Patient:_______________________________ **Date:**________________
Pt's DOB: _____________
Procedure to be done:____

Dear Dr.______________________:

The above named patient is scheduled for oral surgery with or without IV anesthesia in our office on ________________. Peri-operative recommendation is required before we can perform the surgery. Please review this patient's medical history and complete the following.

1. **Does the patient require pre-medication? YES NO**
2. **Are NSAIDS contraindicated? YES NO**
3. **Are narcotic analgesics contraindicated? YES NO**
4. **May the patient stop blood thinner,(Aspirin, Coumadin, Plavix)**
   If so, how many days?___________________
5. **Is the patient taking oral BISPHOSPHONATES YES NO**

Instructions for further treatment:
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Patient's Medical History
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Please List Medications:
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List All Past Surgeries:
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Signature __________________

Doctors Name: _________________________
Phone Number : _________________________

*****PLEASE FAX BACK TO OUR OFFICE AS SOON AS POSSIBLE. *****
Thank you,

Anup Muduli, D.M.D