CHANDLER Dental Health

DATE SENT: _____ DATE REVIEWED: _____

Dear Doctor_____,

We are planning to proceed with dental treatment on our mutual patient,_____ . He/she indicates a history of the following medical problems and listed medications:

_____
_____
_____

- Should any of these medications be modified? Yes No If yes, what modifications?

_____

- Is Antibiotic Prophylaxis required? Yes No If yes, what is recommended regimen?

_____

- Can the patient proceed with dental treatment? Yes No If no, Please provide details.

_____

- Please initial _____ if NO modifications are necessary and you have cleared patient for dental treatment.

PHYSICIAN SIGNATURE _____ DATE _____

Thank you for your prompt reply.

Please fax completed form to:
Chandler Dental Health
480-899-6119- fax
Call us if you need additional information 480-899-6677