

# FAX TRANSMISSION

## Physician's Immediate Reply Requested

### CONFIDENTIAL

|   |  |
|---|--|
| <b>Date:</b> _____  | <b>Pages:</b> _____                        |
| <b>To:</b> _____<br>Physician's name  | <b>Fax:</b> _____<br>Physician's fax no.   |
| <b>From:</b> _____<br>Dentist's name  | <b>Phone:</b> _____<br>Dentist's phone no. |
| <b>Re:</b> _____<br>Patient's name  | <b>Fax:</b> _____<br>Dentist's fax no.     |
| _____<br>Patient's date of birth      Patient's signature authorizing exchange of information between dentist and physician |  |
| <b>Subject: Medical Clearance for Dental Treatment</b>  |  |

**INSTRUCTIONS:** *Dentist - Please complete Section 1 and sign.*  
*Physician - Please complete Section 2, sign and fax back to Dentist.*

|  |   |
|--|---|
| <p><b><u>SECTION 1</u></b></p> <p><i>To be completed by the dentist.</i></p>   | <p>1. Dental Treatment Plan: _____</p> <p>_____</p> <p>2. Patient's condition which may warrant special considerations:</p> <p>_____</p> <p>3. <b>IF</b> prophylactic antibiotic treatment is required, I will follow the current AHA guidelines and prescribe the following protocol and prescription: _____</p> <p>_____</p>  |
| <p><b><u>SECTION 2</u></b></p> <p><i>To be completed by the physician.</i></p> | <p>1. Is the patient healthy enough to undergo this treatment?</p> <p style="text-align: center;">(Please initial)      Yes _____      No _____</p> <p>2. Does the patient's medical condition require prophylactic antibiotic treatment?</p> <p style="text-align: center;">(Please initial)      Yes _____      No _____</p> <p>3. If you recommend a different prophylactic treatment plan or antibiotic, please indicate below:</p> <p>_____</p> <p>_____</p> |

\_\_\_\_\_  
Dentist's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

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