MD CLEARANCE FORM

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.