

# FAX TRANSMISSION

## Physician's Immediate Reply Requested

### CONFIDENTIAL

<b>Date:</b> _____	<b>Pages:</b> _____
<b>To:</b> _____ Physician's name	<b>Fax:</b> _____ Physician's fax no.
<b>From:</b> _____ Dentist's name	<b>Phone:</b> _____ Dentist's phone no.
<b>Re:</b> _____ Patient's name	<b>Fax:</b> _____ Dentist's fax no.
_____	_____
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>	<ol style="list-style-type: none"> <li>1. Dental Treatment Plan: _____ _____</li> <li>2. Patient's condition which may warrant special considerations: _____</li> <li>3. <b>IF</b> prophylactic antibiotic treatment is required, I will follow the current AHA guidelines and prescribe the following protocol and prescription: _____ _____</li> </ol>
<p><b><u>SECTION 2</u></b></p> <p><i>To be completed by the physician.</i></p>	<ol style="list-style-type: none"> <li>1. Is the patient healthy enough to undergo this treatment?  <div style="text-align: center;">(Please initial)      Yes _____      No _____</div> </li> <li>2. Does the patient's medical condition require prophylactic antibiotic treatment?  <div style="text-align: center;">(Please initial)      Yes _____      No _____</div> </li> <li>3. If you recommend a different prophylactic treatment plan or antibiotic, please indicate below:            _____            _____         </li> </ol>

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

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date