Spotsylvania Oral Surgery

MEDICAL CONSULTATION REQUEST

To: Dr. _____ Please complete the form below and return it to

Fax: _____From: Dr. _____

RE: _____ Phone: _____

Date of Birth _____ Fax: _____

Our mutual patient has indicated the following medical condition(s):_____

_____

Please provide us with the following: □PMH □ Medication List □ CBC □Coags (INR/PTT)

The following treatment is scheduled in our clinic: _____

The treatment is planned to be completed under: □ Local Anesthesia □ IV GA □ Nitrous Oxide

Most patients experience the following with the above planned procedures:
bleeding: □ minimal (<50ml) □ significant (>50ml) stress and anxiety: □ low □ medium □ high

_____ _____
Dentist's signature Date

PHYSICIAN'S RESPONSE

Please provide any information regarding the above patient's need for antibiotic prophylaxis, current cardiovascular condition, coagulation ability, and the history and status of infectious diseases. Ordinarily, local anesthesia is obtained with 2% Lidocaine, 1:100,000 epinephrine. For some surgical procedures, the epinephrine concentration may be increased to 1:50,000 for hemostasis. The epinephrine dose NEVER exceeds 0.2 mg total.

*CHECK **ALL** THAT APPLY*

▫ **OK** to **PROCEED** with dental treatment; **NO** special precautions and **NO** prophylactic antibiotics are needed .

□ Antibiotic prophylaxis **IS** required for dental treatment according to the current American Heart Association and/or American Academy of Orthopedic Surgeons guidelines.

□ Other precautions are required: (please list)_____

_____

□ **DO NOT** proceed with treatment. (Please give reason)_____

_____

Treatment may proceed on (Date)_____

□ Patient has an infectious disease:
□ AIDS (please provide current lab results) □ Hepatitis, type _____, (acute/carrier)
□ TB (PPD+/active) □ Other (explain)_____

□ Requested relevant medical and/or laboratory information is attached.

_____ _____
Physician Signature Date

Phone # 540-898-7645 Fax # 540-898-7043