FAX TRANSMISSION
Physician's Immediate Reply Requested
CONFIDENTIAL

Date: _____ **Pages:** _____

To: _____ **Fax:** _____
Physician's name Physician's fax no.

From: _____ **Phone:** _____
Dentist's name Dentist's phone no.

Re: _____ **Fax:** _____
Patient's name Dentist's fax no.

_____ _____
Patient's date of birth Patient's signature authorizing exchange of information between dentist and physician

Subject: Medical Clearance for Dental Treatment

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

SECTION 1 *To be completed by the dentist.*	1. Dental Treatment Plan: _____ _____ 2. Patient's condition which may warrant special considerations: _____ 3. **IF** prophylactic antibiotic treatment is required, I will follow the current AHA guidelines and prescribe the following protocol and prescription: _____ _____
SECTION 2 *To be completed by the physician.*	1. Is the patient healthy enough to undergo this treatment? (Please initial) Yes_____ No_____ 2. Does the patient's medical condition require prophylactic antibiotic treatment? (Please initial) Yes_____ No_____ 3. If you recommend a different prophylactic treatment plan or antibiotic, please indicate below: _____ _____

_____ _____
Dentist's Signature Date

_____ _____
Physician's Signature Date