FAX TRANSMISSION
Physician's Immediate Reply Request
CONFIDENTIAL
Physician-Please complete Section 2, sign and fax back to Dentist.

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

SECTION 1

To be Completed by the dentist.

1. Dental Treatment Plan: **Dental Treatment under general anesthesia which may include x-rays, cleaning, and teeth extractions**
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

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