MEDICAL CONSULTATION REQUEST FOR DENTAL CARE

TO: ______________________________

PHONE: ______________________________

FAX: ______________________________

RE: ______________________________

DOB: ______________________________

Kristina Svensson, DDS

Board Ceritified Pediatric Dentist

SF Pediatric Dentistry

4214 California St, SF, CA 94118

Phone: (415) 613-6123

Fax: (415) 418-6115

Email: hello@SFPediatricDentistry.com

PARENT/GUARDIAN CONSENT

I agree to the release of my child's medical information to SF Pediatric Dentistry.

____

Parent or Guardian Signature and Date

REASON FOR CONSULTATION

1 Our patient has presented with the following medical problem(s): ______________________________

____

2 The following treatment is scheduled in our clinic: ______________________________

____

3 Most patients experience the following with the above planned procedures:

Bleeding: ☐ *minimal (<50mL)* ☐ *significant (>50mL)*

Stress and Anxiety: ☐ *low* ☐ *medium* ☐ *high*

4 Please send: ☐ Summary of medical condition & laste medical visit

☐ Most recent laboratory results

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. The epinephrine dose never exceeds 0.2mg 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

☐ Special precautions are required: (please give reason) ______________________________

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☐ **DO NOT** proceed with treatment: (please give reason) ______________________________

____

☐ Patient has infectious disease:

- ☐ AIDS (Please provide current lab results)
- ☐ Hepatitis, type _____, (acute / carrier)
- ☐ TB (PDD+ / active) Chest X-Ray Clear Y / N

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

____

Physician Signature and Date

We appreciate your assistance in providing optimum care for this patient.

Please have physician sign and fax to (415) 418 - 6115 or email to hello@sfpediatricdentistry.com

** PLEASE COMPLETE AND SIGN **