Washington Township Dental Associates
474 Hurffville Cross-Keys Road, Atrium One, Suite A, Sewell, NJ 08080
Phone: (856) 582-1000 **RETURN TO FAX: (856) 589-1093**
Email: washingtontownshipdental@gmail.com

## CONSULTATION REQUEST/ MEDICAL CLEARANCE FOR DENTAL SERVICES

Date: ___________________________ Patient #: ____________________________

Attn: ____________________________ Fax #: _______________________________

RE: Patient: ____________________________ DOB: _______________________________

**Our mutual patient has chosen to proceed with their dental care in our office that may include:**

___ Cleaning ___ Radiographs ___Fillings, Crowns, Bridges ___Root canal therapy

___ Extractions ___ Nitrous Oxide ___Local Anesthetic ___Other: _______________________

The patient has indicated the following medical conditions:

_____________________________________________________________________________________________

- ➔ ANTIBIOTIC PROPHYLAXIS: ___ YES ___ NO
  - ◆ IF YES, TYPE OF ANTIBIOTIC: _______________________________
- ➔ INTERRUPTION OF ANTICOAGULATION: ___ YES ___ NO, IF YES….
  - ◆ DISCONTINUE ANTICOAGULANT MEDICINE _____ DAY(S) BEFORE DENTAL PROCEDURE
  - ◆ RESUMED ANTICOAGULANT MEDICINE WITHIN _____ DAY(S) AFTER THE DENTAL PROCEDURE.
- ➔ LOCAL ANESTHETIC RESTRICTIONS: (Example: with epinephrine) ___ YES ___ NO
  - ◆ IF YES, PLEASE SPECIFY:_________________________________________________________

    ______________________________________________________________________________
- ➔ OTHER PRECAUTIONS/ADDITIONAL COMMENTS:

  ______________________________________________________________________________

Name of Reporting Physician: ________________________________________________________
Signature of Reporting Physician: ____________________________________________________
Phone # of Reporting Physician: ______________________________________________________

We appreciate your assistance in providing optimum care for this patient. Please have your physician fill out and sign above. Please fax as soon as possible. Thank you.

________________________________________________ ____________________
Treating Dentist Sent By