Consultation Request for Dental Treatment

Immediate Reply Requested

To: _____

Physician's name | Physician's phone | Physician's fax | Physician's Email

From: _____

Dentist's name | Dentist's phone | Dentist's fax | Dentist's Email

Re: _____

Patient's name | Patient's date of birth

_____

Patient's signature authorizing exchange of information between dentist and physician | Date

Our mutual patient, _____, reports the following medical, history, condition(s), prior treatment(s) or prescription(s) and use of medication(s), which may warrant special consideration(s) for dental treatment(s):

_____

_____

Planned dental care, treatment(s) or operation(s) and medications (including Local Anesthesia type):

_____

_____

_____

Dentist's Signature | Date

For the Physician to complete:

1. Regarding information provided above, please confirm the diagnosis and any other related or relevant medical treatment(s), including medications for

   _____

   _____

2. Please note any other medical conditions, medications or concerns in relation to the medical care you have provided for _____ that I should consider when planning for his/her dental treatment? (Enter "none" if not applicable)

   _____

   _____

3. I have concerns about this patient's fitness for the planned dental treatment and request a consultation prior to treatment:

   _____

   _____

   (Please initial) Yes _____ No _____

_____

Physician's Signature | Best telephone number where I may be reached for consultation. | Date

****Please Return Completed form by Fax to:** _____

(Dentist's Fax Number)

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