MEDICAL CONSULTATION REQUIEST

To: Dr. _____

_____

_____

RE: _____

Date of Birth: _____

Please complete the form below and return it to

Dr. Duc Huynh, DDS

4720 Peachtree Industrial Blvd. Unit 5102

Norcross, GA 30071

(P) 770-807-8733

(F) 770-807-8735

Our mutual patient has presented to my clinic with the following medical condition(s):

_____

The following treatment(s) is(are) scheduled in my clinic:

_____

_____

_____ _____

Dentist's Signature Date

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.

Please 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 Orthopetic Surgeons guidelines.

__ **Other precautions** are required: (please list) _____

_____

__ **DO NOT** proceed with treatment. (please give reason) _____

_____

_____ _____

Physician's signature: Date

Patient's Consent: I agree to the release of my medical information to the above named dentist.

_____ _____

Patient's Signature Date