Coastal Bend COLLEGE

MEDICAL CONSULTATION REQUEST

To Dr._____

Fax: _____

Patient Name:_____

Date of Birth:_____

Please complete the form below and return to:

COASTAL BEND COLLEGE DENTAL HYGIENE DEPARTMENT

Phone: 361-354-2555 Fax: 361-371-8355

The patient has presented with a history of the following medical condition(s), including date of occurrence:

_____ **Date:**_____

_____ **Date:**_____

_____ **Date:**_____

The following treatment is scheduled in our clinic:_____

Student:_____ **Date:**_____

PHYSICIAN'S RESPONSE

Please provide information regarding the above patient's need for antibiotic prophylaxis, current cardiovascular condition, coagulation ability and/or the history and status of infectious diseases.

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. **This pre-medication will be required:**
_____ indefinitely **OR** _____ for the specified period of time post-event/procedure _____ years

_____ Other precautions are required (please list): _____

_____

_____ **DO NOT** proceed with treatment (provide reason):_____

_____

_____ Treatment may proceed on (date): _____

Patient has an infectious disease:

_____ AIDS (please provide lab results) _____ Hepatitis, Type _____ (acute / carrier)

_____ TB (PPD+/active) _____ Other (explain)_____

_____ Requested relevant medical and/or laboratory information is attached

Physician's Signature:_____ Date:_____

PATIENT CONSENT

I agree to the release of my medical information to the Coastal Bend College Dental Hygiene Department

Patient's Signature:_____ Date:_____

Revised: Oct-2020