For CRDTS Use Only

CRDTS Medical Clearance Form

Dental Patient Information:

Name: _____
DOB: _____
Date patient scheduled to sit for CRDTS Exam:_____

Physician/Dentist of Record Information:

Name: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

Dear Doctor:

Our mutual patient (listed above) is scheduled for dental hygiene treatment as part of a clinical board exam. Treatment during the exam will include: Dental Prophylaxis (deep scaling, cleaning and polishing), Periodontal Probing and an Intra/Extra Oral Assessment.

The medical history completed by this patient indicates a history of:

_____
_____
_____

Please evaluate this patient's medical history and advise us to any special considerations that should be made for this patient with regard to the dental hygiene treatment they have scheduled.

Physician or Dentist of Record to complete section below:

Would you recommend any treatment modifications for this patient? ☐ No ☐ Yes
If yes, specify: _____

Is antibiotic prophylaxis necessary? ☐ No ☐ Yes
If yes, specify: _____

Can local anesthetic be used on this patient? ☐ Yes ☐ No
If yes, can local anesthetic with epinephrine be used? ☐ Yes ☐ No

Additional comments:

_____
_____
_____

Physician or Dentist of Record (please print): _____

Physician or Dentist of Record Signature: _____

Date Signed: _____

Thank you for your assistance in providing optimum care for this patient. *CRDTS2015*