JOHN C. DI GRAZIA, D.D.S., Ltd.
1625 Lakeside Drive - Reno, Nevada 89509
Telephone 775-786-2077

Request for Medical Consultation

Dear Doctor:

Your patient, whose name appears to the right, is also a current patient of ours. We have noted the potential problem(s) listed below and believe that the patient's medical condition may influence the dental care we are recommending. We would appreciate your assessment and recommendations. This consultation will be used to evaluate the patient's health prior to proceeding with dental treatment as well as to determine any needed modifications for dental care.

Patient Name _____

DOB _____ LLUSD# _____

SSN _____

I authorize release of any medical or other information necessary to process this request for medical consultation.

_____ _____
Patient's Signature Date

Patient's medical condition which may warrant special considerations for dental treatment: _____

Proposed dental treatment:
☐ Exam and radiographs ☐ Teeth cleaning ☐ Extraction(s) or surgery
☐ Root canal therapy ☐ Fillings ☐ Crowns ☐ Other _____

Dental work will be done using the following medication(s):
☐ Local anesthesia with vasoconstrictor _____
☐ Local anesthesia, plain
☐ Nitrous oxide analgesia (≤ 50% N_2O)
☐ Intravenous conscious sedation
☐ Other(s) _____

Medical information requested: _____

Consultation requested by: _____ and _____
Name Date

SECTION BELOW TO BE COMPLETED BY THE PHYSICIAN

1. Is the patient healthy enough to undergo the proposed treatment? *(Please Initial)* ***Yes*** _____ ***No*** _____
2. Does the patient's medical condition require antibiotic prophylaxis? *(Please Initial)* ***Yes*** _____ ***No*** _____
   If yes, diagnosis of condition necessitating antibiotic prophylaxis: _____
3. Are there any other contraindications or precautions for dental treatment? *(Please Initial)* ***Yes*** _____ ***No*** _____
   If yes, explain: _____
4. Does patient require any modification in his/her medical treatment in order to undergo dental treatment safely?
   (Please Initial) ***Yes*** _____ ***No*** _____ ***If yes, explain:*** _____

_____ Phone# _____ FAX # _____
Physician's Signature

_____ _____
Date Time

Print Name _____
Office Address _____
City, State, Zip _____

☐ Please FAX response as soon as possible to out office at 775-786-0146. Keep a copy for your records.
☐ Keep this FAX for your records, it serves as documentation of consultation obtained by telephone conversation.