To: 
(Physician Name)

From: Howard Modiano, DDS
       Dental Services, Gurwin Jewish Nursing & Rehabilitation Center

Subject: DENTAL CLEARANCE

Date: __________________________

For your patient __________________________ to receive dental services at the Gurwin Adult Day Health Program, please complete questions 1, 2 & 3.

The following procedure(s) are offered:
       Dental Prophylaxis (cleaning)
       Routine restorations of teeth requiring local anesthesia
       Minor dental surgery (extraction of non-restorable erupted teeth)
       Fabrication or repair of complete and/or partial dentures

1. Can patient undergo dental treatment in an outpatient ambulatory clinic setting?  
   YES [ ]  NO [ ]

2. Are there any changes to the patient=s medication prior to dental treatment?  
   (i.e. changes in Coumadin Therapy, ASA, etc.)
   YES [ ]  Changes needed: ____________________________________________
   NO [ ]

AHA ANTIBIOTIC PROPHYLAXIS GUIDELINES  Usually needed for:

Artificial Heart Valves * H/O Infective Endocarditis * Total Joint Replacement with Immunosuppression (RA, IDDM, SLE, Hemophilia, HIV infection, Malignancy, Malnourishment, Drug or Radiation-induced) or Previous Artificial Joint Infection * Cardiac Transplant which develops a Heart Valve Problem * Certain specific, serious Congenital Heart Conditions (unrepaired or incompletely repaired cyanotic congenital heart disease, including those with palliative shunts and conduits - a completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter interventions, during the first six months after the procedure - any repaired congenital heart defect with residual defect at the site or adjacent to the site of a prosthetic patch or prosthetic device)

3. Does patient require antibiotic prophylaxis prior to dental care?  YES [ ] NO [ ]
   If so, indicate Antibiotic: __________________________  Known Allergies : __________________________

   Standard:  AMOXICILLIN 2gm, 1 hr. prior [ ]
   If Allergic:  CLINDAMYCIN 600mg, 1 hr. prior [ ]

Thank you for your prompt attention to this matter.

MD Signature: __________________________  Date: __________________________

Print Name: __________________________  Adm. Dental Clearance
Rev: 3/12/09