68 Hauppauge Road, Commack, NY 11725
(631)715-2520 Fax (631)715-2915

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**
(Registrant's Name)
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: ______________________________