For CRDTS Use Only

CRDTS Medical Clearance Form

This form is only needed for patients who have conditions requiring Medical Clearance.

Candidate to complete this top section:

Dental Patient Information:
Name:______________________________
DOB: ______________________________
***Date patient scheduled to sit for CRDTS Exam**:__________________

Medical or Dental Provider Information:
Name:____
Address: ____
City/State/Zip: ____________________________________
Phone:_________________Fax: ____________________

Dear Provider:

Our mutual patient (listed above) is scheduled for dental or dental hygiene treatment as part of a clinical board examination.

The medical history (see attached CRDTS medical history screening form) completed by this patient indicates a medical concern of:

____

____

Primary Care Provider or Dentist of Record to complete section below:

Please evaluate this patient's medical history and advise us on any special considerations that should be made for this patient regarding the dental treatment and/or periodontal therapy they have scheduled.

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

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

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

Is high blood pressure (160/95 to 179/109) a concern for this patient? ☐ Yes ☐ No
Note: CRDTS guidelines state patients with a BP 180/110 or above are NOT allowed to sit for this exam.
If yes, would you allow this patient to sit for the CRDTS exam if they had a blood pressure reading in the range of 160/95 to 179/109? ☐ Yes ☐ No

Additional comments:

____

____

Provider (please print): ____

Provider Signature: ____

*Date Signed: ______________

***Must be signed within 30 days of the above exam date listed.**

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