

## 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: \_\_\_\_\_

**Medical or Dental Provider Information:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

**\*Date patient scheduled to sit**

City/State/Zip: \_\_\_\_\_

**for CRDTS Exam:** \_\_\_\_\_

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.*

CRDTS 2024