

Date: [Date]

To: [Dentist Name]
[Dental Clinic Name]
[Clinic Address]

RE: Medical Clearance for [Patient Name]

Date of Birth: [Patient DOB]

Dear Dr. [Dentist Last Name],

The above-named patient is currently under my care for the following cardiac conditions:
[List Cardiac Conditions, e.g., Valvular Heart Disease, Atrial Fibrillation]

Proposed Dental Procedure: [List Procedure, e.g., Extraction, Root Canal]

Cardiac Clearance Status:

- The patient is cleared for the procedure without specific cardiac restrictions.
- The patient is cleared for the procedure with the recommendations listed below.

Anticoagulation / Antiplatelet Management:

- Continue current medication (e.g., Aspirin, Warfarin, Clopidogrel, DOAC).
- Hold medication for [Number] days prior to procedure.
- Other instructions: [Specify]

Antibiotic Prophylaxis:

- Recommended for prevention of Infective Endocarditis.
- Not required based on current AHA/ACC guidelines.

Anesthesia Recommendations:

- Epinephrine-containing local anesthetic is acceptable.
- Limit Epinephrine to 1:100,000 (Maximum 2 cartridges).
- Avoid Epinephrine.

Additional Comments:

[Insert any additional clinical notes]

If you have any further questions, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Cardiology Practice Name]