Date: [Date]
Patient Name: [Patient Full Name]
Date of Birth: [Patient DOB]
Proposed Surgery: [Type of Joint Replacement, e.g., Total Hip/Knee Arthroplasty]
Scheduled Surgery Date: [Surgery Date]

To [Orthopedic Surgeon Name],

I have performed a comprehensive dental evaluation on the patient listed above. This evaluation included a clinical examination and necessary radiographs to identify any potential sources of oral infection or dental disease that could complicate their upcoming orthopedic surgery.

Clinical Findings:

- [ ] The patient is dentally fit. No active dental infections, abscesses, or severe periodontal disease were identified.
- [ ] Necessary dental treatment has been completed as of [Date].
- [ ] Dental treatment is required but will not interfere with the surgical schedule.

Clearance Status:

[ ] **CLEARED:** The patient is dentally cleared for their joint replacement surgery. No active oral focal infection was found.
[ ] **NOT CLEARED:** The patient is not cleared at this time due to [Reason].

Recommendation for Future Dental Work:

Post-operatively, we will follow the AAOS/ADA guidelines regarding antibiotic prophylaxis for dental procedures. We recommend the patient avoid elective dental cleanings for [Number] months following the joint replacement unless otherwise specified by your office.

Sincerely,

Dentist Signature: _____
Dentist Name: [Print Name]
Office Name: [Dental Practice Name]
Phone Number: [Phone Number]