

Date: [Date]

To: [Dentist/Oral Surgeon Name]

Clinic Name: [Clinic Name]

Fax/Address: [Fax Number or Address]

RE: Medical Clearance for Dental Procedure

Patient Name: [Patient Name]

Date of Birth: [Date of Birth]

Diagnosis: [Type 1 / Type 2 Diabetes Mellitus]

Dear Dr. [Dentist Last Name],

The patient listed above is currently under my care for the management of diabetes. They are scheduled for the following dental procedure: [Description of Procedure].

Current Diabetes Status:

- Most recent HbA1c: [Value]% performed on [Date]
- Current Medications: [List Insulin/Oral Medications]
- Glycemic Control: [Stable / Fair / Poor]

Recommendations for Procedure:

- **Procedural Timing:** Morning appointments are preferred to minimize disruption to the patient's meal and medication schedule.
- **Dietary Status:** [NPO / Light breakfast permitted].
- **Medication Adjustment:** [No changes / Take half dose of basal insulin / Hold morning oral medications].
- **Glucose Monitoring:** Blood glucose should be checked immediately prior to the procedure. If glucose is below [Value] mg/dL or above [Value] mg/dL, please reschedule.
- **Infection Control:** Prophylactic antibiotics are [Recommended / Not required] from an endocrinology standpoint due to [Reason].

Medical Clearance:

The patient is medically cleared to proceed with the planned dental treatment, provided that the above recommendations are followed and proper monitoring of blood glucose levels is maintained throughout the perioperative period.

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

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Department of Endocrinology]
[Facility Name]