

Date: [Date]

To: [Dentist Name]

Clinic Name: [Dental Clinic Name]

Fax/Phone: [Clinic Contact Information]

RE: Medical Clearance for Dental Procedures

Patient Name: [Patient Full Name]

Date of Birth: [Patient Date of Birth]

Dear Dr. [Dentist Last Name],

The above-referenced patient is currently under my care for the management of [**Type of Epilepsy/Seizure Disorder**].

Current Neurological Status:

The patient's seizures are currently [stable / well-controlled / frequent]. Last seizure occurred on [Date].

Medications:

The patient is currently prescribed the following anti-epileptic drugs (AEDs):
[List Medications and Dosages]

Recommendations for Dental Treatment:

- **Clearance:** The patient is medically cleared to undergo [routine dental work / oral surgery / extractions].
- **Anesthesia:** [Local anesthesia is safe / Avoid epinephrine if applicable / Consultation with anesthesia required for sedation].
- **Stress Management:** Stress and sleep deprivation can lower the seizure threshold; appointments should be kept short and scheduled during the patient's optimal time of day.
- **Emergency Protocol:** In the event of a seizure during the procedure, please follow standard seizure first aid, protect the airway, and administer [Rescue Medication Name/Dose] if the seizure lasts longer than [Number] minutes.

Precautions/Contraindications:

[Insert any specific drug interactions or contraindications, e.g., "Avoid certain antibiotics that may interact with AEDs"].

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

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Neurology Practice Name]
[Contact Information]