

Date: [Date]

To: [Dentist Name / Dental Clinic Name]

From: [Nephrologist Name]

Patient Name: [Patient Full Name]

Date of Birth: [Date of Birth]

To Whom It May Concern,

The above-named patient is currently under my care for End-Stage Renal Disease (ESRD) and receives regular dialysis treatments. They are scheduled for the following dental procedure:
[Description of Dental Work].

Dialysis Schedule: [Days of the week: e.g., Mon/Wed/Fri]

Dialysis Access Site: [Location and Type: e.g., Left Arm AV Fistula / Chest Catheter]

Clinical Recommendations:

- **Timing:** Dental procedures should ideally be performed on non-dialysis days.
- **Antibiotic Prophylaxis:** [Yes/No] - [Specific medication/dose if required].
- **Anticoagulation:** The patient receives heparin during dialysis. Please perform dental work at least [Number] hours post-dialysis to ensure adequate clotting.
- **Blood Pressure Management:** Avoid using the arm with the vascular access for blood pressure cuffs.
- **Bleeding Risk:** [Specific instructions regarding aspirin or other anticoagulants].

The patient is medically cleared to undergo the planned dental procedure provided the above precautions are followed.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Clinic/Hospital Name]

[Phone Number]