

Date: [Date]

To: [Dentist Name]

Clinic: [Dental Clinic Name]

Fax/Email: [Contact Information]

RE: Medical Clearance for Dental Procedures

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

To Whom It May Concern,

The above-named patient is currently under my care for [Diagnosis/Condition]. Due to their underlying condition and/or current treatment regimen, the patient is considered immunocompromised.

Current Clinical Status:

- Most recent Absolute Neutrophil Count (ANC): [Value] (Date: [Date])
- Most recent Platelet Count: [Value] (Date: [Date])
- Current Medications: [List Medications, e.g., Biologics, Steroids, Immunosuppressants]

Recommendations for Dental Treatment:

- **Antibiotic Prophylaxis:** [Required / Not Required] per AHA/AAOS guidelines.
- **Bleeding Risk:** [Low / Moderate / High]. Local hemostatic agents are [Recommended / Not Necessary].
- **Procedure Timing:** Proceed with dental treatment. It is recommended to perform procedures [Number] days after/before medication infusion/injection.
- **Precautions:** Strict adherence to sterile technique and monitoring for post-operative infection is advised.

The patient is medically cleared to undergo the following dental procedures: [List Procedures, e.g., Routine Cleaning, Extraction, Root Canal].

If there are signs of systemic infection or if significant bone surgery is planned, please contact my office prior to proceeding.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Specialty: Immunology/Rheumatology]

[Phone Number]