Date: [Date]

To: [Pediatric Dentist/Oral Surgeon Name]
Facility Name: [Dental Office Name]
Fax/Email: [Contact Information]

RE: Medical Clearance for Dental Procedure

Patient Name: [Patient Name]
Date of Birth: [Patient Date of Birth]
Diagnosis: [Specific Congenital Condition]

To Whom It May Concern,

[Patient Name] is currently under my care for the management of [Name of Congenital Condition]. I understand that the patient is scheduled to undergo the following dental procedure: [Name of Procedure] on [Date of Procedure].

Medical Status:
The patient is currently medically [stable/unstable]. Their most recent evaluation was on [Date of Last Visit].

Cardiac/Systemic Considerations:
[Specify if prophylactic antibiotics are required per AHA guidelines, or list specific precautions regarding congenital heart defects or other systemic issues].

Anesthesia/Sedation Recommendations:
The patient is cleared for:
[ ] Local Anesthesia
[ ] Nitrous Oxide
[ ] Conscious Sedation
[ ] General Anesthesia (Hospital Setting Recommended: Yes/No)

Medications:
Current medications include: [List Medications].
Adjustments needed for procedure: [List Adjustments or "None"].

Clearance Statement:
From a medical standpoint, [Patient Name] is cleared to proceed with the planned dental treatment with the following restrictions: [List Restrictions or "None"].

Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Title/Specialty, e.g., Pediatric Cardiologist]
[Practice Name/Hospital]