

MEDICAL CONSULTATION FORM

Holmes Endodontics
3712 Wilmington Pike
Kettering, OH 45429
(937)-240-3024

Date of Medical Consultation Request: _____

To: _____

Re: _____

Patient Name

Date of Birth

Our mutual patient has presented to my office, with the following medical condition(s):

_____.

I have recommended the following treatment/procedure: _____

_____.

_____ anesthesia is planned.

The procedure will be performed in an Office Setting.

After reviewing this patient's health history, my medical consultation questions to you include:

_____.

Please return this completed Medical Consultation Form by: (*date* _____) via _____
or other secure transfer method.

We greatly appreciate your input regarding our mutual patient's care. Please contact me directly with any question regarding this consultation request at (937)-240-3024.

Requesting Doctor's Name

Requesting Doctor's Signature

Date

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PHYSICIAN'S RESPONSE

There are medical contraindications to the:

- proposed treatment/procedure? Yes No
- anesthesia plan? Yes No

If yes, what are they? _____

Do you recommend any modifications to the patient's current prescribed medications related to the proposed procedure? Yes No

If yes, what are they? _____

Are there any additional precautions you recommend to the proposed procedure? Yes No

If yes, what are they? _____

Are there any lab test or additional testing you recommend before the proposed procedure? Yes No

If yes, what are they? _____

Please contact me directly with any question regarding this consultation request at: _____.

Medical Consultant Physician's Signature

Date

Responses can be returned with patient or by email to frontdesk@daytonrootcanal.com