For CRDTS Use Only

CRDTS Medical Clearance Form

Candidate to complete this top section:

Dental Patient Information:

Name: _____

DOB: _____

***Date patient scheduled to sit for CRDTS Exam**:_____

Physician/Dentist of Record Information:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Dear Doctor:

Our mutual patient (listed above) is scheduled for dental hygiene treatment as part of a clinical board exam. Treatment during the exam will include: Dental Prophylaxis (deep scaling, cleaning and polishing), Periodontal Probing and an Intra/Extra Oral Assessment.

The medical history (see attached CRDTS medical history screening form) completed by this patient indicates a medical concern of:

_____

_____

Physician or Dentist of Record to complete section below:

Please evaluate this patient's medical history and advise us on any special considerations that should be made for this patient with regard to the dental hygiene treatment they have scheduled.

Would you recommend any treatment modifications for this patient? ☐ No ☐ Yes

If yes, specify: _____

Is antibiotic prophylaxis necessary? ☐ No ☐ Yes

If yes, specify: _____

May local anesthetic be used on this patient? ☐ Yes ☐ No

If yes, may local anesthetic with epinephrine be used? ☐ Yes ☐ No

Is high blood pressure (160/95 to 179/109) a concern for this patient? ☐ Yes ☐ No

Note: CRDTS guidelines state patients with a BP 180/110 or above are NOT allowed to sit for this exam.

If yes, would you allow this patient to sit for the CRDTS exam if they had a blood pressure reading in the range of 160/95 to 179/109? ☐ Yes ☐ No

Additional comments:

_____

_____

Physician or Dentist (please print): _____

Physician or Dentist Signature: _____

*Date Signed: _____

***Must be signed within 30 days of the above exam date listed.**

Thank you for your assistance in providing optimum care for this patient. *CRDTS2017*