

The DDD Foundation, Inc.
Dentistry for the Developmentally Disabled
3103 Clairmont Road NE,
Suite C
Atlanta, Ga. 30329
Office) 404/942-0086 fax) 404/942-0088

Date: _____

Dear Dr.: _____

Your patient, _____ was referred for dental treatment.
We are requesting cardiac clearance for dental treatment under IV conscious sedation.
Please respond to the items below:

_____ Patient is at low risk from a cardiac standpoint.

_____ Patient at high risk from a cardiac standpoint because of the
following reasons:

_____ Are prophylactic antibiotics necessary to prevent bacterial endocarditis for dental
procedures? YES NO

If antibiotics are necessary, please list type and dosage:

_____ Can the patient tolerate extended surgical procedures including extractions? YES NO

_____ Does the patient have hypertension? YES NO

_____ Does the patient have hypotension? YES NO

_____ Does the patient have any arrhythmias? YES NO

If yes, is it adequately controlled to allow dental treatment including extractions? YES NO

_____ Does the patient have a pacemaker? YES NO

_____ Does the patient have valvular issues? YES NO

_____ Has the patient had cardiac arrest. YES NO

If yes, please list date

How often is the patient seen for follow up? _____

Physician's Signature: _____ Date: _____

Comments: _____

