LAKE LAND COLLEGE

Request for consideration of Prophylactic Antibiotics prior to dental treatment

Dental Hygiene Clinic
Allied Health Division
Lake Land College
5001 Lake Land Blvd.
Mattoon, IL 61938
Phone: 217-234-5201
Fax: 217-234-5248

Patient's Name: _____

Patient's Address: _____

Patient's Date of Birth: _____

I, the undersigned, grant permission to any physician, dentist, clinic, or hospital to release to the Lake Land College Dental Hygiene Clinic all information concerning my present and/or past medical or dental condition and treatments.

Patient or guardian signature: _____ Date:_____

Dear Doctor or Hospital:

Mr. Mrs. Ms. _____ reported to the Lake Land College Dental Hygiene Clinic on _____ for dental hygiene care which included periodontal procedures (subgingival scaling/root planning) that will create bacteremia. The patient's review of medical history indicates that one or more of the below listed conditions now exist or existed at one time:

_____Prosthetic cardiac valves
_____Unrepaired cyanotic congenital heart disease including those with shunts/conduits
_____Completely repaired congenital heart disease with prosthetic material or device
_____Cardiac transplantation with valvular disease
_____Immunocompromised/Immunosuppressed
_____Previous bacterial endocarditis
_____Repaired congenital heart disease with residual heart defects
_____Surgically constructed systemic pulmonary shunts or conduits (during the 1st 6 months after)
_____Joint replacement
_____Other (please specify)_____

We are requesting a professional explanation of this patient's condition(s) and for your consideration of the need for prophylactic antibiotics prior to dental treatment. If antibiotics are recommended prior to dental treatment, we ask that you would prescribe the appropriate antibiotic regimen and advise this patient on the proper administration of this medication. Any further recommendations you may contribute to assist in the dental treatment of this patient are greatly appreciated. Thank you.

Medical Findings, recommendations, and antibiotic regimen if prescribed:

Printed name of physician: Phone number: Fax number:

Physician's Signature:_____Date:_____

Updated 8/28/2020