DENTAL CLEARANCE FOR CARDIAC SURGICAL AND CATHETERIZATION PROCEDURES

Please complete this form and fax or email to:
Cardiac Intake Center
Fax: 215-590-6820
Telephone: 215-590-2774
Email: cardiacsched @chop.edu

Patient's Name: _____

DOB: _____ Date of last dental evaluation: _____

Instructions: Please respond by checking the appropriate boxes and providing additional information where indicated.

	Yes	No
This patient has an active infectious oral disease	○	○
This patient has a current condition that is expected to cause a problem in the next 6–12 months (* i.e. caries, root canals, crowns)	○	○
This patient has been treated for a recent oral infection a. The treatment is complete and consisted of: (COMMENT BELOW) _____	○	○
b. The patient will require more treatment to resolve an active oral infection	○	○
I have not seen the patient recently, and therefore cannot provide a current assessment	○	○

Comments:

Dentist Signature: _____ Date: _____

Dentist Name (Print}: _____

Address: _____

Phone number: _____

**Any procedures requiring surgery, devices/hardware, and/or pacemaker will require a delay in dental treatments for 6-12 months*

Children's Hospital of Philadelphia®
Cardiac Center

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