Dental Clearance Letter

Re ______________________________ DOB____________________ MRN___________

To Whom It May Concern: Our mutual patient noted above is in process of undergoing optimization for total joint replacement surgery. Prior to scheduling surgery, it is important to verify that the patient has no current dental infection and not at risk for imminent infection. Please choose from one of the two options below:

___ This patient is optimized for surgery and requires no further treatment or workup prior to proceeding with surgery.

___ This patient is NOT medically optimized and will require the additional evaluations as noted below for the special concerns noted below:

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I certify that the patient has had a dental exam within the past 6 months and does not have a dental infection requiring treatment.

Dentist name (please print): ______________________________________

Dentist signature: ____

Date:_____________________

This letter is an important part of our preoperative patient evaluation; please fax this letter back to us as soon as possible.

Thank you for your assistance,
Dr. Daniel Del Gaizo

PLEASE FAX THIS LETTER TO UNC Orthopaedics Attn: Dr. Daniel Del Gaizo (919) 966-6730