Toothpicks
Medical Review Form for Dental Work

Resident Name: _____Date of Birth:_____

If resident has had this form previously filled out and has NOT had any changes in their health, please print and sign your name here;

_____

If changes are present, please list them; _____

_____

For new residents to Toothpicks, please answer/update the following questions and attach a copy of the MAR (medication administration record), answers must be YES or NO.

1. Does the resident Have any prosthesis? Ie. hip/knee Replacement, pacemaker,	YES/NO	If yes, please elaborate with dates of placement:
2. Does the resident have any heart condition(s)? ie. Heart murmur, valve replacement, congenital defect?	YES/NO	If yes, what does the physician recommend as prophylaxis prior to dental care?
3. Is the resident currently on any blood thinners? Please list	YES/NO	If yes, does the physician recommend stopping use prior to dental care? Is the INR within normal limits?
4. Does the resident have any allergies?	YES/NO	If yes, please list:
5. Is there any other important information we should know about the resident? Ie. Diabetes, radiation/chemotherapy, organ transplant, Rheumatic fever, immunosuppression, recent surgery?	YES/NO	If yes, please list:
6. Does the resident require antibiotics prior to dental work?	YES/NO	If yes, list known reason:

Completed by:_____

Signed :_____ Date: _____