TAVR DENTAL CLEARANCE FORM

Please complete this form as soon as possible and fax it to us.

Also bring a copy to your pre-procedure appointment.

FAX Numbers

Akron General Hospital: 330.344.0112

Fairview Hospital: 440.333.5015

Hillcrest Hospital: 216.427.9022

Cleveland Clinic doctor's name: _____

Patient's name: _____

Patient's DOB: _____ Patient's Cleveland Clinic #: _____

The patient is scheduled for a structural heart procedure the week of: _____/_____/_____

The patient must have a dental exam that includes full-mouth X-rays and/or Panorex at least 6 months before the procedure. The patient cannot be cleared for the procedure if there are any signs of acute infection.

Date of patient's last dental exam: _____/_____/_____

Is the patient cleared for the procedure? ___ **Yes** ___ **No**

If no, please call the patient's Cleveland Clinic doctor. Phone# _____

Dentist's name: _____

Dentist's signature: _____

Date: _____/_____/_____ Time: _____

Dentist's phone #:_____ Dentist's fax #: _____

Thank you for your cooperation!

This information is not intended to replace the medical advice of your healthcare provider. Please consult your healthcare provider for advice about a specific medical condition or treatment.

Cleveland Clinic