Dear DENTIST:

Our mutual patient has failed conservative management and is considering their surgical options, including TOTAL KNEE ARTHROPLASTY. Our patient will be scheduled to return to our office approximately 2-3 weeks prior to the potential surgery date for a pre-operative appointment. Should the patient decide surgical intervention will be pursued at that time, we will require verification that the patient does not have any ongoing oral issues that would limit their surgical options.

I have asked our patient to contact your office for DENTAL evaluation and any specialized testing or procedures which you may feel is necessary prior to proceeding with joint replacement. Your assistance would be greatly appreciated in helping ensure the best potential surgical outcome possible. As you know, our concern is with any dental or oral infection that may exist which would prevent surgical intervention from being successful.

I respectfully request that you assist us in assuring that this patient is dentally optimized pre-operatively for their upcoming joint replacement. It would be helpful if you could communicate with us your recommendations and results once you have completed your examination.

Either myself, or my physician's assistant will be available for coordination of care by calling (910) 295-0224. You may fax copies of your results/recommendations to (910) 295-7954.

For your convenience we have included a form which might facilitate the communication process.

Thank you for allowing us to participate in the care of your patients, we look forward to coordinating care up-coming.

Sincerely,

John R. Moore, IV

John R. Moore, MD

Pinehurst Surgical Clinic

Orthopedics Department

(910) 295-0224

DENTAL RECOMMENDATION FOR (PATIENT NAME/DATE of BIRTH) _____

SURGERY RECOMMENDATIONS:

☐ PATIENT **DOES NOT** have oral infection and may proceed with surgery

☐ PATIENT **DOES HAVE ACTIVE ORAL INFECTION** and I have recommended the following treatments:

_____

_____

☐ PATIENT IS NOT RECOMMENDED FOR SURGERY AT THIS TIME due to extensive dental issues.

Provider Signature: _____

Provider Name: _____

Date: _____

PLEASE FAX TO (910) 295-7954

Pinehurst Surgical Clinic-Orthopedics Department

Dr. John R. Moore