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Medical Consultation

Dentist: _____

Address: _____

Patient: _____

Date: _____

Reason for consultation

Dear Dr: _____

Our mutual patient presented at our office ___ / ___ / ___ . During the medical history review, the patient stated that he/she is taking an anticoagulant medication. Our office requires an INR reading of <4, seventy-two hours prior to scheduling dental treatment. Please inform our office when this target has been reached so that dental treatment may be initiated.

Your assistance is appreciated. Thank you.

Sincerely,

I hereby consent to the release of my medical records to Dr. Mark Davenport & Associates including any information regarding my International Normalized Ratio. I understand that this information will remain confidential.

Sincerely,

Physician's Response

Please fax copy of patient's INR results.

Physician's Signature: _____

Date: ___ / ___ / ___