Dear DENTIST:

Our mutual patient has failed conservative management and is considering their surgical options, including TOTAL HIP 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 with my Physician's Assistant, Michelle Moore. 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) 215-2655 (ATTN: Michelle Moore, PA-C) as necessary.

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:

Proceed

Proceed with the following recommendations: ____

____

____

____

Further evaluation/treatment needed including: ____

____

____

Cancel anticipated surgical procedure until further notice.

Provider Signature: ____

Provider Name: ____

Date: _________________

PLEASE FAX TO (910) 215-2655

Pinehurst Surgical Clinic-Orthopedics Department

Dr. John R. Moore