



Date: \_\_\_\_\_

Dear Dental Health Professional: \_\_\_\_\_

Our son/daughter, \_\_\_\_\_, has an inherited bleeding disorder. Good oral health is important to his/her overall health, but certain procedures may cause increased bleeding. Most dental procedures can safely be managed at local dental offices; however, collaboration with our child's bleeding disorders comprehensive program is important. The following is basic information about his/her bleeding disorder and contact information for the bleeding disorders comprehensive program.

Type and severity of bleeding disorder: \_\_\_\_\_

Medications used to treat or prevent bleeds: \_\_\_\_\_

Additional medicines needed for oral care: \_\_\_\_\_

Special considerations: \_\_\_\_\_

Central venous access device: \_\_\_\_\_ yes/no

**When to treat and how to treat are decisions that we would like to make in conjunction with our bleeding disorders team. Their contact information is as follows:**

Hemophilia Treatment Center (HTC): \_\_\_\_\_

Medical Director: \_\_\_\_\_

**Nurse Coordinator (Primary Contact):** \_\_\_\_\_

Contact Phone/Fax: \_\_\_\_\_

*Thank you for your special care of my child.*

\_\_\_\_\_ (Parent/Guardian)