Medical Order Request Form

Standing Order valid 24 months from date of signature

Date:_____

Patient Name:_____DOB:_____

Residing at:_____

Patient's Specific Medical Condition:_____

Patient may have Oral Hygiene Services, including oral screening, oral prophylaxis, periodontal screening, non-surgical periodontal therapy, chlorhexidine, irrigation, sealants and fluoride treatments by Dental Hygiene In Home, Registered Dental Hygienist in Alternative Practice, PRN at the patient's residence, due to the patient's disability/inability to travel and to be treated in a dental office.

Does this patient have any medical history concerns that would require pre-medication therapy?

No_____
Yes_____ Reason for premed_____
Medication you would like to prescribe_____
Please call in the prescription to patient's pharmacy

If the patient is on an anticoagulant, should this medication be stopped prior to treatment?

N/A_____
No_____
Yes_____ Number of days before_____

Is there any other reason for medications to be added/discontinued or altered prior to treatment?

No_____
Yes_____ Reason_____

Physician's Signature:_____ Date:_____

Physician's License#_____