Medical Order Request Form

Standing order valid 24 months from date of signature

To:_____Date:____/____/_____

Patient Name:_____DOB:_____/_____/_____

Residence/Address: _____

Patient's Specific Medical Condition: _____

Due to the patient's disability and/or inability to travel and be treated in a dental office, the patient may receive ORAL HYGIENE services performed by Elyse Cop RDHAP, at the patient's residence. Services may include oral/periodontal screenings, oral prophylaxis, nonsurgical periodontal therapy, periodontal maintenance, scaling and root planing and any of the following: Chlorhexidine, Fluoride, Arestin, Oraqix (2% lidocaine/ 2% prilocaine), 20% benzocaine topical or occlusal sealants.

Physician's Signature:_____ License # _____

- Does this patient need pre-treatment antibiotic therapy? ___ No ___Yes
- Please indicate any medical conditions or concerns that would require pre-medicated prophylaxis for the above such as:

____ Endocarditis ____ MVP w/ regurgitation ____ Recent heart surgery
___ Pacemaker/Defibulator ____ Severe Heart Disease ____ Surgical shunt
Other surgery: ___Hip ___Knee ___Joint Other:_____
Other reason: _____

- If so, what medication will you be prescribing?
  _____
- 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/additional reason for any medications to be added/discontinued or altered prior to treatment? ___No ___Yes Reason: _____

Thank you for your prompt response.

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