Physician Consultation Form

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Client Name: _____ Date: _____

Date of Birth: _____ Phone # _____

Above named client has requested dental hygiene services at Old Dominion University Dental Hygiene Care Facility. The client has reported taking the listed medication(s) and/or has the following medical condition that may require special precautions.

_____
_____
_____

Before a student clinician can initiate dental hygiene treatment, we need to know if the client needs an antibiotic prophylaxis regimen and/or if other precautions are necessary to prevent complications and to ensure the health and safety of the client.

*PLEASE FILL OUT THE SECTION BELOW AND FAX THE ENTIRE FORM BACK TO THE ODU DENTAL HYGIENE CARE FACILITY (757-683-3970).

Prophylactic Premedication

☐ DOES NOT require pre-medication prior to receiving dental hygiene services

☐ REQUIRES pre-medication prior to receiving dental hygiene services. If so:

☐ ☐

Other Precautions

☐ DOES NOT require special precautions prior to receiving dental hygiene services.

Please indicate the specific pre-medication regimen or other precautions that need to be taken to safely treat this client:

_____
_____

Dr. _____ Date: _____
Address: _____ Phone: # _____