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 and/or has the following medical condition that may require special precautions.

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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:**

PLEASE CHECK if a single dose of antibiotics will cover this patient sufficiently for 8 hours in the event the patient has two appointments in one day. **YES**_____**NO**______

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:

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Dr. ____________________________________ Date:______________________

Address: ____Phone: #____________________