SoCal Dental Hygiene Group
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Medical Order Request

Standing Order Valid 24 Months from Date of Signature

To:______________________________ Date:_____________

Fax:______________________________

Patient Name:_________________________________ DOB:_____________ SS#_______________

Patient may have **Oral Hygiene Services** including: Oral Screening, Oral Prophylaxis, Periodontal Screening, Non-Surgical Periodontal Therapy, Chlorhexidene Gluconate Irrigation, and Fluoride Treatments by the Registered Dental Hygienist in Alternative Practice. PRN at the Patient's residence due to their Disability and/or Inability to travel and be treated in a Dental Office.

Is There Need for Pre-Treatment Antibiotic Therapy?: YES NO
(Circle One)

If Yes, What Medication and Procedures would you like to prescribe?

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What is the Medical Condition Limiting Patient from access to Care?

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If Patient is on Anti-Coagulant, should this be stopped prior to treatment? **YES** **NO**
if yes, how many days?________

Is there any other/additional reasons for Medication to be added/discontinued or altered? **YES** **NO**
Explanation:________________________________

Physician Name (Printed):____

Physician Signature:____

Date: _____________