Medical Order Request Form

Standing order valid 24 months from date of signature

To: _____

Date: _____/_____/_____

Patient Name: _____ DOB: ____/____/_____

Residence: _____

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 s**ervices performed by **Annik Ohaness, RDHAP**, at the patient's residence. Services may include oral/periodontal screenings, oral prophylaxis, nonsurgical periodontal therapy, periodontal maintenance, scaling/ root planing and any of the following: Chlorohexidine, Fluoride, Oraqix (2% Lidocaine/ 2% Prilocaine), 20% benzocaine topical or occlusal sealants.

Does this patient need Pre-Treatment Antibiotic Therapy? ____Yes ____No

Please indicate any medical conditions or concerns that would require pre-medicated prophylaxis such as:

____ Endocarditis ____ MVP w/ regurgitation ____ Recent hear surgery ____ Pacemaker

____ Severe Heart Disease ____ Surgical shunt ____ Other surgery: ___ Hip ___ Knee ___ Joint

Other: _____

*If so, please specify which antibiotic treatment you will be prescribing?

_____

*If the patient is on an anticoagulant, should this medication be stopped prior to dental hygiene 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: _____

Physician's Signature: _____ **License #: _____**

Please email this approved request and any Rx needed to my office.

Annik Ohaness, RDHAP Lic # HAP 882
Phone: 818-660-6730
annik@annikohanessrdhap.com