Physician Diabetes 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 they are diabetic.

Please complete all parts of the following form, sign, and fax back to 757-683-3970

Date of last A1c test: _____________________ A1c Result: _____________

Patient interval of A1c testing required by physician (**please check**):

☐Every 3 months ☐Every 6 months ☐Every 12 months

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

Patient is cleared for dental hygiene treatment, providing these precautions are followed:

______**DOES NOT** require special precautions prior to receiving oral health services based on the patient's reported A1c

______**REQUIRES** other precautions: ____

Dr. __________________________________ Date: _________________________

Address: ____ Phone: #______________________