

**MOBILE DENTAL HYGIENE CARE (MDHC)**  
**Medical Order Request (MOR)**

Doctor \_\_\_\_\_ Date \_\_\_\_\_

FAX \_\_\_\_\_ Phone \_\_\_\_\_

Participant Name \_\_\_\_\_ DOB \_\_\_\_\_

Residing at \_\_\_\_\_

Participant may have Preventive Oral Hygiene Services, PRN by the Registered Dental Hygienist in Alternative Practice (RDHAP).

Does this participant have any medical concerns that would require premedication with antibiotics prior to a dental cleaning? YES \_\_\_\_\_ NO \_\_\_\_\_

Hip/Knee/Joint Replacement                       Mitral Valve Prolapse  
 Heart murmur     Pacemaker    Other \_\_\_\_\_

Medication you will prescribe \_\_\_\_\_

Physician Signature \_\_\_\_\_ License # \_\_\_\_\_

Thank you for your quick response.                      Please fax this approved request to:

**FAX 888-315-4645**