Sound Dental Care
P.O. Box 46 Keyport, WA 98345
P / 206-745-3808 F / 206-745-3811

Request for Consultation

To Primary Care Provider: ______________________________

Regarding Individual or Resident: ______________________

Residential Facility if Indicated: ______________________

Fax Number of Facility: ____________________________

Date of Request: ______________________________

The Individual, Resident, or their Guardian has requested dental hygiene treatment. The treatment will involve initial evaluations, oral infection control through removal of bacterial debris by scaling and root debridement, possible denture/partial denture cleaning, and application of topical fluorides for caries prevention, as needed. The scaling and debridement are likely to cause gingival bleeding, transient bacteriemia and concern for persons who receive anticoagulants. Topical anesthetic and oral rinses may be used. Appointments are scheduled 45 to 60 minutes in length. Follow-up appointments will be scheduled as needed with the consent of the Individual or Guardian. The Client will be referred to their dentist of record for comprehensive dental services.

Please complete the following orders by circling yes or no.

Resident may have dental hygiene services as needed. **Yes** **No**

Comment: ______________________________________

Resident requires Antibiotic pre-medication. **Yes** **No**

Rx: ______________________________________

Comment: ______________________________________

Other: ______________________________ **Yes** **No**

Rx: ______________________________________

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Comment: ______________________________________

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Primary Care Provider Signature

Date ______________

PLEASE FAX COMPLETED FORM TO SOUND DENTAL CARE
F / 206-745-3811 FORM WILL BE KEPT ON FILE WITH THE CLIENT'S MEDICAL RECORDS.

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