

**adha** **CELL 2015**  
**92<sup>ND</sup> ANNUAL SESSION** **JUNE 17-23\*2015**  
**SESSION** **NASHVILLE, TN**

**CE Course Handout**

**The Role of the Dental Hygiene  
Professional in the Delivery of  
Interprofessional Health Care**

**Saturday, June 20, 2015  
10:00am-12:00pm**



American  
Dental  
Hygienists'  
Association

Patient Name:  
DS Student T Plan Date:

Chart #:

Today's Date:

Student Name:

Category-Assessment	Significant Findings:	Considerations and Risks for DH Treatment <sup>(Std 7)</sup>
Systemic Diseases <sup>(Std 2)</sup>		
Medications <sup>(Std 2)</sup>		
Pulse Rate:      Respiration:	Blood Pressure: 1 <sup>st</sup> reading:                      2 <sup>nd</sup> reading	
MCS Classification:	ASA Classification:	
Dental History and Oral Health Literacy <sup>(Std 7)</sup>	Date of Last DH Treatment: ____ / ____ / ____	
Health Behavior Risks <sup>(Std 7)</sup>	Smoking status: Current    Former    Never (circle one)	
Cultural Factors <sup>(Std 7)</sup>		
Chief Concern:		
Extra/Intra Oral Examination :		
<b>Dental Hygiene Diagnosis and Prognosis <sup>(Std 4,6,7)</sup></b>		
<b>DH Diagnostic Statements</b>	<b>Dental Hygiene Interventions/Goals</b>	<b>Expected Outcomes</b>

The treatment plan recommended above has been thoroughly discussed with me. I have had the opportunity to ask questions and have been advised of the treatment alternatives and risks. I understand that as treatment proceeds it may be necessary to alter the treatment plan, which may affect the estimated treatment time and cost. I will receive an explanation and be advised of any additional fees. I understand that there has been no guarantee of specific results of treatment. I voluntarily consent to the treatment outlined above. <sup>(Std 4)</sup>

Patient Signature:

Date:

Student Signature:

ID Number:

Date:

Faculty Signature:

ID Number:

# Interprofessional Collaboration Form for the Oral Case Manager

Adapted from NYU College of Dentistry Dental Hygiene Programs

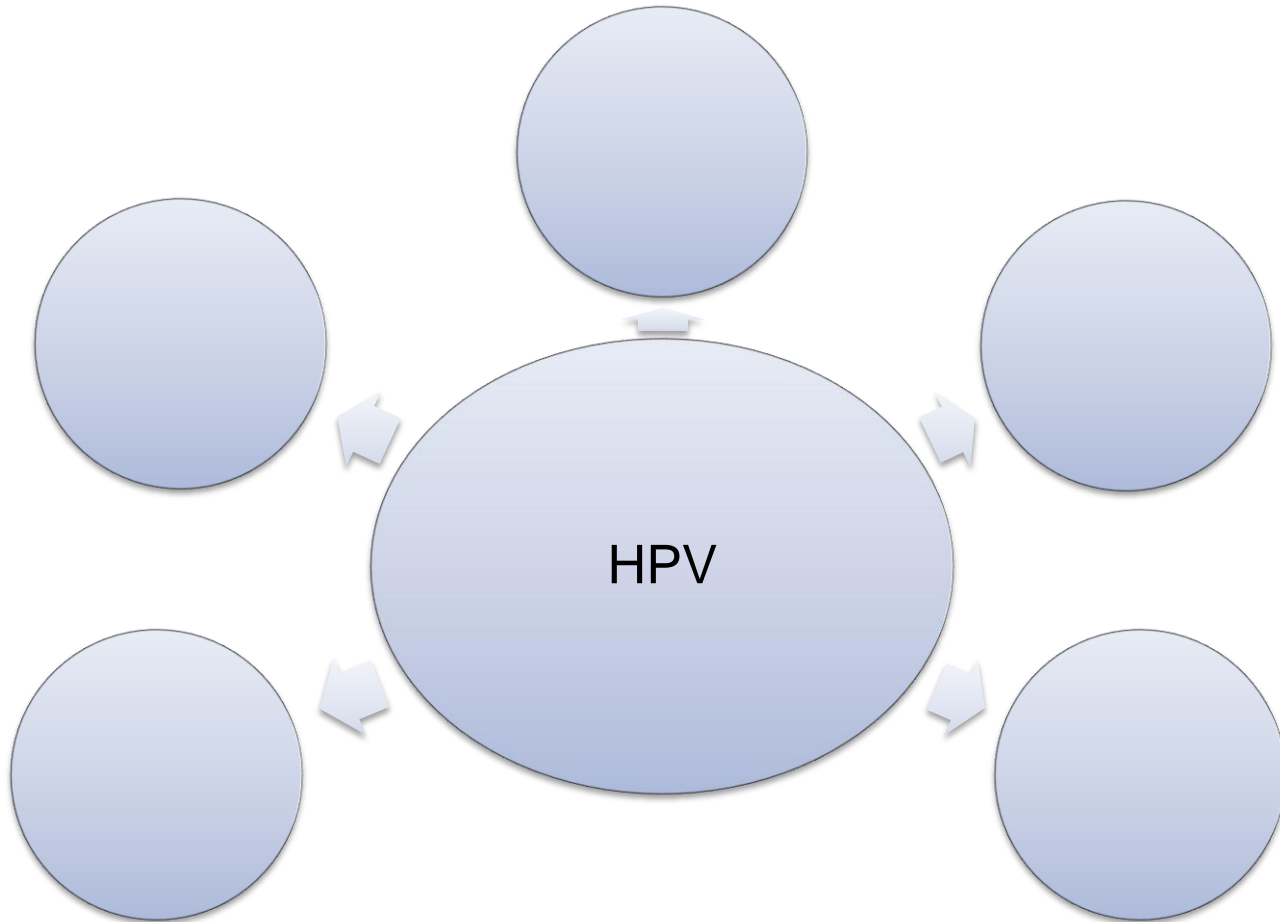
Health History Summary: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Current Medications: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Healthcare Provider	Contact Information	Recommendations for Dental Care
Dental Specialist:		
Primary Care Physician:		
Medical Specialist (i.e. cardiologist, pulmonologist, podiatrist, etc.):		
Physician Assistant or Nurse Practitioner:		
Pharmacist:		
Mental Health Care Provider:		
Family Support:		
Counselors:		
Nutritionist:		



# Case study



# Case study

