Prevent ☀ Educate ☀ Care

Pediatric Dental Initiative

Protocols & Referral Forms

(Referring to PDI for dental treatment requiring general anesthesia)

Content

- Protocols
- Dental Surgery Referral Form
- Dental Screening Forms (2)
- Health & Physical (H&P) Form
- Pediatric Anesthesia Questionnaire
Protocols for Referring to PDI
Before considering referring a patient to PDI for dental surgery services requiring general anesthesia, please read through the following carefully.

Eligible patients as of November 2008:

MEDICAL PROTOCOLS
- Only refer: Age 6 and under; Age 14 and under for patients with developmental disability.
- Health & Physical (H&P) to be reviewed by our anesthesiologist, prior to scheduling.
- We cannot treat patients with significant cardiovascular, pulmonary or renal disease
- ASA I and II are acceptable
- ASA III may be referred elsewhere

DENTAL PROTOCOLS
The surgery center does offer:
- simple extractions (non-surgical)
- fillings
- temporary caps (not permanent)
The surgery center does not offer:
- root canal treatment
- surgical extractions
- crowns on permanent teeth
- bridges
- extraction of wisdom teeth
- "major" reconstructive dentistry

Severity: Determining if a patient should be put under general anesthesia for dental treatment should be done in accordance with the American Academy of Pediatric Dentistry Guidelines, where the use of general anesthesia is contraindicated in healthy, cooperative patients with minimal treatment needs (please complete the Dental Screening form included with packet).

DIGITAL PHOTOS: X-rays have been taken, please enclose with the referral. If patient is uncooperative, please send digital photographs of patient’s mouth clearly showing any identifiable decay so we can determine how much time to schedule for treatment. Doing so will help us more efficiently schedule, and treat, patients.

Insurance: Patients must currently be enrolled in an insurance program. Please contact a PDI case manager with questions about insurances we accept.

Uninsured patients: If all available insurance options have been pursued and coverage is still unavailable, a PDI case manager should be contacted.

1. The following forms must be completed by the person indicated and returned to PDI to determine eligibility:
   - Dental Surgery Referral Form – Completed by the referring dentist
   - Dental Screening Form – Completed by the referring dentist (please enclose dental x-rays)
   - Pediatric Anesthesia Questionnaire – Completed by patient’s guardian
   - Health & Physical (H&P) Form - Completed by patient’s physician
   - Copy of medical and dental insurance Card

2. PDI case managers will work with the referring case manager/agency and/or family to coordinate and discuss the following with the family & ensure privacy practices are upheld:
   - Required pre- and post-operative dental and medical examinations.
   - History & Physical Form
   - Authorizations to Use or Disclose Protected Health Information.
   - Acknowledgement of Receipt of Notice of Privacy Practices.
   - Parent/Legal Guardian Consent and Release Form.
   - Transportation & Scheduling - $30 security deposit required in some cases.
   - Overview of the surgery and pre-op steps (food, drink, medication, etc.).
   - Ask if a dentist or anesthesiologist has discussed the procedure with the family.
   - Contact family and remind them when it’s time for their 6 month dental exam.
   - Help family find a local dental home, if needed.

If you have any questions or need additional materials, please contact Wendy Lopez at 707-838-6560, or by e-mail at wlopez@pedidental.org
Dental Surgery Referral Form

Please fax this form to PDI at 707-837-8877. If you are unable to fax, please mail it to 1380 19th Hole Drive Windsor, CA 95492. Thank You!

☐ Sonoma  ☐ Mendocino  ☐ Lake  ☐ Napa  ☐ Marin  ☐ Other ________________________________

Referring Case Manager/Admitting Physician: ____________________________

Contact/Business Number: ____________________________ Fax Number: ____________________________

Address: ____________________________________________

(Street) (City) (State) (Zip)

Procedure: ____________________________  Diagnosis: ____________________________

Patient’s Name: ____________________________ D.O.B: ___ / ___ / ___  ☐Male ☐Female

Check all that apply:  MediCal ☐ Healthy Families ☐ Healthy Kids ☐ Kaiser ☐ CCS ☐ NBRC ☐ Other ☐

Name of Insurance__________________________ ID#__________________ SS#______-______-________

Contact & Responsible Person: ____________________________ Relationship: ____________________________

Patient’s Phone: ( ) _____-______ Families Primary Language: English ☐ Spanish ☐ Other ☐

Patient’s Address: ____________________________________________

(Street) (City) (State) (Zip)

Check all that apply:  Caucasian ☐ African-American ☐ Hispanic ☐ Asian ☐ Other ☐

Is Patient on any medication or have a medical condition?  NO   YES ____________________________

Does Patient have any allergic reactions to anything?  NO   YES ____________________________

Is Patient latex sensitive?  NO, YES____________________________________________________

Is Patient Uncooperative?  NO, YES__________________________________________________

Is Patient Special Needs? NO, YES (Specify below)

Down syndrome ☐ Autism ☐ Cerebral Palsy ☐ Mental Retardation ☐ Other ☐

_______________________________________________________________________________________________

I AUTHORIZE THE SHARING OF MY CHILD’S MEDICAL RECORDS BETWEEN_____________________________AND PDI. I HAVE RECEIVED THE PRIVACY PRACTICES (HIPPA).

YO AUTORIZO EL INTERCAMBIO ENTRE___________________________________Y PDI DEL HISTORIAL MEDICO DE MI HIJO (A) Y HE RECIBIDO INFORMACION DE LAS PRACTICAS DE PRIVACIDAD (HIPPA).

SIGNATURE/FIRMA___________________________________ DATE/FECHA________/________/__________
To be filled out by referring dentist

REDWOOD EMPIRE SURGERY CENTER:
DENTAL SCREENING Page 1
Required as of 11/12/08

Note to offices/clinics: The Redwood Empire Surgery Center only provides care to children under general anesthesia. By referring this patient you are stating that you feel it is in the best interest of this patient to receive a general anesthetic for completion of dental treatment. This decision should be made only after a complete examination in your office/clinic. Thank you.

Patient Name: ___________________________ Date: ______________
Referring Clinic/Office: ___________________________ Clinic Phone #: ______________
Dental screening performed by: ___________________________ Performed on: ______________

Reason for Referral for Treatment under General Anesthesia (you must choose at least one for the referral to be complete):

- [ ] Lack of Patient Cooperation
- [ ] Distance to travel to specialty care
- [ ] Amount of treatment necessary
- [ ] Developmental disability/delay
- [ ] Local anesthesia ineffective
- [ ] Pre-cooperative Age
- [ ] Fear/Anxiety

**In accordance with the American Academy of Pediatric Dentistry Guidelines the use of general anesthesia is contraindicated in healthy, cooperative patients with minimal treatment needs.**

Treatment has been attempted: [ ] YES  [ ] NO
X-Rays/Radiographs have been obtained: [ ] YES  [ ] NO  [ ] Enclosed
Prophy has been done: [ ] YES  [ ] NO

ESTIMATE OF AMOUNT OF TREATMENT NECESSARY:

- [ ] Mild Dental Problems - no pain or infection, visual spots without cavitation
- [ ] Moderate Dental Problems - obvious lesions with cavitation
- [ ] Severe Dental Problems - pain, infection, large lesions, immediate needs

Please list/mark carious teeth:

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DIGITAL PHOTOS/X-RAYS: If X-rays have been taken, please enclose with the referral. If patient is uncooperative, please send digital photographs of patient’s mouth clearly showing any identifiable decay so we can determine how much time to schedule for treatment. Doing so will help us more efficiently schedule, and treat, patients.
PREOPERATIVE HISTORY AND PHYSICAL

<table>
<thead>
<tr>
<th>DATE OF EXAM</th>
<th>TIME</th>
<th>NAME</th>
<th>AGE</th>
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CHIEF COMPLAINT

PRESENT ILLNESS

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<tr>
<th>PAST HISTORY</th>
<th>NONE</th>
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<th>IF YES, PLEASE SPECIFY</th>
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<td>OPERATIONS</td>
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<td>TRANSFUSIONS</td>
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<td>BLEEDING PROBLEMS</td>
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<td>INJURIES</td>
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<tr>
<td>ILLNESSES</td>
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<td>ALLERGIES (including food, medications, and latex)</td>
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<tr>
<td>PROBLEMS WITH GROWTH AND DEVELOPMENT</td>
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</table>

OTHER RELEVANT PAST, FAMILY BEHAVIORAL AND SOCIAL HISTORY (including psychosocial needs, if any):

CURRENT MEDICATIONS:

PHYSICAL EXAM:

GENERAL APPEARANCE: ☐ Normal

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<tr>
<th>SKIN</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS/HX</th>
<th>ABDOMINAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS/HX</th>
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<td>LYMPH SYSTEM</td>
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<td>BREAST</td>
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<td>CHEST</td>
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<td>OTHER</td>
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</table>

OTHER EXAM FINDINGS (CONTINUE ON OTHER SIDE IF NECESSARY):

IMPRESSION:

PLAN:

☐ Patient is cleared for General Anesthesia. (please check if applicable)

Physician Signature ___________________________ Address ___________________________
Print Name ___________________________ Phone ___________________________

To be filled out by Patient’s Physician
Child’s Name: ____________________________
Age: _______ years _______ months     Sex: M / F

Name of the child’s parent or legal guardian who will accompany the child to and from the surgery center and will be available during the surgery and postoperatively: __________________________________________________________
Phone number: ____________ Phone (on day of surgery eg: cell phone or pager) ________________
Reason for Surgery: __________________________________________________________
Has your child had any of the following? Check the appropriate box. If “yes” then specify.

Yes  No  Comments
☐  ☐  Any previous surgeries?
☐  ☐  Any problems with anesthesia? Any blood relatives of the patient have problems with anesthesia, including malignant hyperthermia?
☐  ☐  Any medical problems presently or in the past?
☐  ☐  Any medications (prescription & non-prescription) now or recently taken by your child?
☐  ☐  Any use of steroids (such as cortisone or prednisone) within the last year, including breathing treatments?
☐  ☐  Any medical devices or machines used?
☐  ☐  Any allergies (including medication or latex reactions)?
☐  ☐  Any problems at birth, such as prematurity, use of oxygen or machine ventilation? Specify:
☐  ☐  Any exposure to cigarette smoke? Exposure to drugs?
☐  ☐  Any recent colds or respiratory infections? Cough with sputum?
☐  ☐  Any difficulty breathing, such as wheezing or asthma?
☐  ☐  Any problems with snoring or stopping breathing during sleep?
☐  ☐  Any problems with shortness of breath or excessive fatigue when playing, crawling, walking, or running? “Turning blue”?
☐  ☐  Any history of heart problems, heart murmur, irregular heartbeat?
☐  ☐  Any special tests or surgery on the heart?
☐  ☐  Any history of seizures, epilepsy, or passing out?
☐  ☐  Any muscle weakness, myopathy, or muscular dystrophy?
☐  ☐  Any other physical disabilities?
☐  ☐  Any history of diabetes? Hormonal problems?
☐  ☐  Any bleeding or clotting problems with the child or any blood relatives?
☐  ☐  Any heartburn or acid reflux of the stomach?
☐  ☐  Any history of jaundice or hepatitis?
☐  ☐  Any kidney problems?
☐  ☐  Any exposure to chicken pox in the last two weeks?
☐  ☐  Are immunizations up to date?
☐  ☐  Any loose teeth? Chipped or broken or missing teeth, braces, retainers?
☐  ☐  Any other medical problems?
☐  ☐  Any special concerns about your child?
☐  ☐  Does your child have any special concerns about surgery or anesthesia?
☐  ☐  Does your child have a special toy or blanket that can comfort him? If so, you may bring it to surgery.

Name of Pediatrician ____________________________ Phone number: ____________
Any Specialist doctors who provide care for your child? (Name and Specialty) ____________________________ Phone Number: ____________

This information is true and accurate to the best of my knowledge.

Parent/Guardian signature: ____________________________ Date: ____________

Redwood Empire Surgery Center, Inc.
Pediatric Anesthesia Questionnaire
Nombre de su hijo: ____________________________

Edad: _______años _______meses  |  Sexo:  M / F

Nombre del padre o tutor legal del menor que lo acompañará al centro de la cirugía y lo retirara de el y que estará disponible durante cirugía y después de la operación: ____________________________

Numero de teléfono: ___________  |  Teléfono (el día de la cirugía, p. ej. celular o pager) ___________

Motivo de la cirugía: ____________________________________________________________

¿A su hijo se le aplica alguna de las siguientes opciones? Marque la casilla que corresponda. En caso afirmativo, especifiquese.

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<tr>
<th>Si</th>
<th>No</th>
<th>Comentarios</th>
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<tr>
<td>♡</td>
<td></td>
<td>¿Se ha sometido a alguna cirugía previa?</td>
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<td>¿Ha tenido problemas con la anestesia? ¿Algún pariente consanguíneo del paciente ha tenido problemas con la anestesia, incluida hipertermia maligna?</td>
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<td>♡</td>
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<td>¿Tiene o ha tenido algún problema medico?</td>
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<td>¿Su hijo toma o ha tomado recientemente algún medicamento (con y sin receta)?</td>
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<td>¿Ha usado corticosteroides (tales como cortisona o predisona) dentro del ultimo ano, incluidos tratamientos respiratorios?</td>
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<td>¿Ha usado algún dispositivo o maquina medica?</td>
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<td>¿Tiene alguna alergia (inclusas reacciones a los medicamentos o al latex)?</td>
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<td>¿Ha tenido algún problema al nacer, tales como nacimiento prematuro, uso de oxigeno o ventilación mecánica? Especifique:</td>
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<td>¿Ha estado expuesto a humo de cigarillo? ¿Ha estado expuesto a las drogas?</td>
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<td>¿Recientemente tuvo algún resfrió o infección respiratoria? ¿Ha tenido tos con espuito?</td>
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<td>¿Tiene a a tenido alguna dificultad para respirar, como sibilancia o asma?</td>
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<td>¿Tiene problemas de ronquido o de dejar de respirar durante el sueno?</td>
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<td>¿Tiene problemas de respiración entrecortada o fatiga excesiva al jugar, gatear, caminar, o correr? ¿Se “pone azul”?</td>
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<td>¿Se ha realizado alguna prueba o cirugía de corazón especial?</td>
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<td>¿Tiene antecedentes de problemas del corazón, soplo cardiano, latidos cardiano irregulares?</td>
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<td>¿Tiene antecedentes de convulsiones, epilepsia, o desvanecimiento?</td>
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<td>¿Tiene debilidad muscular, miopatía, o disfroga muscular?</td>
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<td>¿Tiene alguna otra incapacidad física?</td>
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<td>¿Tiene antecedentes de diabetes? ¿Tiene problemas hormonales?</td>
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<td>¿El menor o algún pariente consanguíneo tienen problemas de sangrado a de coagulación?</td>
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<td>¿Tiene acidez estomacial o reflujo acido del estomago?</td>
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<td>¿Tiene antecedentes de ictericia o hepatitis?</td>
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<td>¿Tiene algún problema renal?</td>
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<td>¿Ha estado expuesto a la varicela en las ultimas dos semanas?</td>
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<td>¿Esta al día con las inmunizaciones?</td>
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<td>¿Tiene algún diente flojo? ¿Tiene dientes astillados, rotos o faltantes, frenos o retenciones?</td>
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<td>¿Tiene algún otro problema medico?</td>
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<td>¿Tiene alguna preocupación especial con respecto a su hijo?</td>
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<td>¿Su hijo tiene alguna preocupación especial con respecto a la cirugía o la anestesia?</td>
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<td>¿Su hijo tiene algún juguete o manta especial que le sirva de consuelo? En tal caso, puede traerlo para la cirugía.</td>
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Nombre del Pediatra___________________________  |  Numero de teléfono:___________________________

¿Su hijo recibe cuidados de algún medico especialista? (Nombre y especialidad)

___________________________________________________________________________  |  Numero de teléfono:___________________________

A mi leal saber y entender, esta información es verdadera y exacta.

Nombre del padre/tutor: ____________________________  |  Fecha: ____________________________

Redwood Empire Surgery Center, Inc.  
Pediatric Anesthesia Questionnaire