pdi
Pediatric Dental Initiative

H&P form MUST be COMPLETED and submitted with referral packet for patient to be scheduled.

Protocols for Referring to PDI

Before considering referring a patient to PDI for dental treatment services requiring general anesthesia, please read through the following carefully.

Eligible patients as of August 1, 2023 we will treat three categories of patients:

MEDICAL PROTOCOLS

1. Children between ages 1-7 with severe caries and age associated inability to cooperate for dental care, up to age 10 for children with significant emotional, physical, or behavioral barriers to cooperation for dental care.

2. Patients between the ages of **1 - 25** years with developmental disabilities that make dental care problematic without the services of an anesthesiologist.

DENTAL PROTOCOL

PDI **does** offer:

- Simple extractions (non-surgical)
- Fillings
- Temporary silver caps (not permanent)

PDI **does not** offer:

- **Root canal** treatment on permanent teeth
- Surgical extractions
- Crowns on anterior permanent teeth
- Bridges
- Extraction of wisdom
- "Major" reconstructive dentistry
- Implants
- Braces

If you have any questions or need additional information please contact our Patient Care Coordinators at 707-838-6560, or by e-mail at Referrals@pdisurgerycenter.org

A COMPLETE REFERRAL PACKET MUST INCLUDE:

☐ **Dental Referral forms, pages 1, 2 & 3** - Completed by the referring dentist (enclose dental X-rays, treatment plan and Medical Necessity or criteria indications for GA)

☐ **Preop H&P form** - within 30 days of referral date - **MUST BE COMPLETED** by patients medical provider

☐ **Pediatric Anesthesia Questionnaire** - **MUST BE COMPLETED** by parent/legal guardian and included when sending referral

☐ **Copy of medical and dental insurance card**

PDI Patient Care Coordinators will contact families once COMPLETED referral forms have been received.

All forms are available under the resource link at www.pdisurgerycenter.org

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TO BE FILLED OUT BY REFERRING DENTIST

Dental Referral Form

Please e-mail this form to PDI Patient Care Coordinators at referrals@pdisurgerycenter.org

☐Sonoma ☐Mendocino ☐Lake ☐Napa ☐Marin ☐Other_____

Referring Dentist/Dental Clinic: _____

Contact/Business Number: _____ **E-mail:** _____

Address:_____
(STREET) (CITY) (STATE) (ZIP)

Patient Name:_____ **D.O.B:** _____/_____/_____ ☐ Male ☐ Female

Check all that apply: ☐**MediCal** ☐**Partnership** ☐**Kaiser** ☐**North Bay Regional** ☐**Other**_____

Name of Insurance _____ ID# _____ SS# _____

Contact & Responsible Person: _____ Relationship: _____

Patient's Phone: ( ) _____ - _____ E-mail: _____

Patient's Address: _____
(STREET) (CITY) (STATE) (ZIP)

Families Primary Language: English☐ Spanish☐ 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) Down syndrome☐ Autism☐ Cerebral Palsy☐
Developmentally delay☐ Other☐_____

I AUTHORIZE THE SHARING OF MY CHILD'S MEDICAL RECORDS BETWEEN _____ AND PDI. I HAVE RECEIVED THE PRIVACY PRACTICES (HIPAA).

YO AUTORIZO EL INTERCAMBIO ENTRE _____ Y PDI DEL HISTORIAL MEDICO DE MI HIJO (A) Y HE RECIBIDO INFORMACION DE LAS PRACTICAS DE PROVACIDAD (HIPAA).

SIGNATURE/FIRMA _____ DATE/ECHA ___/____/_____

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TO BE FILLED OUT BY REFERRING DENTIST

Dental Screening Page 1

Required as of August 1, 2023

Note to offices/clinics: (PDI) Pediatric Dental Initiative only provides care to children under general anesthesia. We must ensure that all patients meet our clinical guidelines to ensure safe, and quality treatment plans are performed. 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. *Thank you.*

Patient Name: _____ Date: _____

Referring Clinic/Office: _____ Clinic Phone #: _____

Dental screening performed by: _____

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

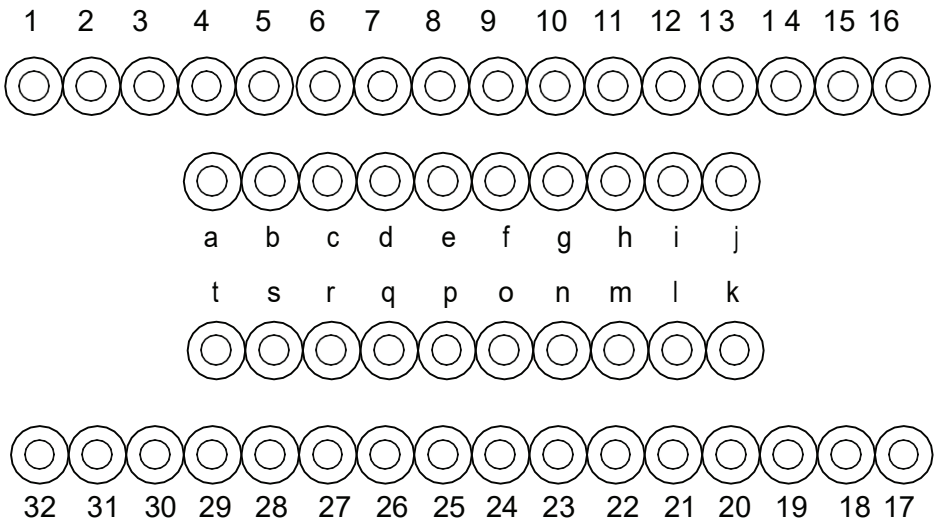
- ☐ Lack of Patient Cooperation
- ☐ Amount of treatment necessary
- ☐ Local anesthesia ineffective
- ☐ Fear/Anxiety
- ☐ Distance to travel to specialty care
- ☐ Developmental disablilty/delay
- ☐ Pre-cooperative age

• *In accordance with the America 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/Radio-graphs have been obtained ☐ YES ☐ NO ☐ Enclosed

Prophy has been done: ☐ YES ☐ NO



Tooth	Treatment Necessary

DIGITAL PHOTOS/X-RAYS: If X-rays have been taken, pleaser enclose with the referral or e-mail referrals@pdisurgerycenter.org 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.

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TO BE FILLED OUT BY REFERRING DENTIST

Dental Screening Page 2

Required as of August 1, 2023

Patient Name: _____ Date: _____

The Department of Health Care Services (DHCS) has change the delivery to those patients who require Deep sedation/general anesthesia for their dental needs. Please note the new criteria indications listed below:

Criteria Indications for General Anesthesia

Behavior modification and local anesthesia shall be attempted first. General anesthesia shall then be considered if this fails or is not feasible based on the medical needs of the patient.

If the provider includes clear medical record documentation of **both** number 1 and number 2 below, then the patient shall be considered for general anesthetic.

☐ 1. Use of local anesthesia to control pain failed or was not feasible based on the medical needs of the patient.

☐ 2. Use of conscious sedation, either inhalation or oral, failed or was not feasible based on the medical needs of the patient.

If the provider documents any one of numbers 3 through 6 then the patient shall be considered for deep sedation/ general anesthetic.

☐ 3. Use of effective communicative techniques and the inability for immobilization (patient may be dangerous to self or staff) failed or was not feasible based on the medical needs of the patient.

☐ 4. Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation.

☐ 5. Patient has acute situational anxiety due to immature cognitive functioning.

☐ 6. Patient is uncooperative due to certain physical or mental compromising conditions.

Please mark statements above that apply to this patient. Please send all documentation of any treatment attempted. Please justify and document medical necessity for patient to be treated under general anesthesia. Please fill-out narrative below or send chart notes documenting necessity. Treatment must be pre-authorized by patient's insurance to undergo dental treatment under general anesthesia.

Referring Dentist's Signature is required.

_____

_____

_____

_____

_____

_____ Date: _____

Dentist Signature and Date

Please add additional sheets if needed. Thank you!

To be filled out by Medical provider

(Once completed please e-mail and provide a copy to family)
Referrals@pdisurgerycenter.org

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Pediatric Dental Initiative
1380 19th Hole Drive
Windsor, CA 95492
Phone (707) 838-6560

PREOP HISTORY & PHYSICAL within 30 days of referral

EXAM DATE / /	TIME	NAME	DOB: / /

CHIEF COMPLAINT

PRESENT ILLNESS

PAST HISTORY	NONE	YES	IF YES, PLEASE SPECIFY
OPERATIONS	☐	☐	
PREMATURE	☐	☐	
BLEEDING PROBLEMS	☐	☐	
INJURIES	☐	☐	
ILLNESS (HX ASTHMA)	☐	☐	
ALLERGIES (including food, medications and latex)	☐	☐	
PROBLEMS WITH GROWTH AND DEVELOPMENT	☐	☐	

OTHER RELEVANT PAST, FAMILY, BEHAVIORAL AND SOCIAL HISTORY (including psychosocial needs, if any). Family history of GA problems.

CURRENT MEDICATIONS:

PHYSICAL EXAM: weight:_____ height: _____ BMI: _____

GENERAL APPEARANCE: ☐ Normal

	NORMAL	ABNORMAL FINDINGS/HX		NORMAL	ABNORMAL FINDINGS/HX
HEAD	☐		ABDOMINAL	☐	
EYES	☐		GU SYSTEM	☐	
ENT/ Tonsils apnea/snoring	☐		RECTAL	☐	
NECK	☐		EXTREMITIES	☐	
CARDIAC	☐		NEURO	☐	
MURMUR?	☐		LYMPH SYSTEM	☐	
CHEST "LUNGS"	☐		SKIN	☐	
			OTHER	☐	

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

IMPRESSIONS:

PLAN:

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

Physician Signature _____
Print Name _____
Date _____

Address _____
_____
Phone _____

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PDI Pediatric Anesthesia Questionnaire

Child's Name: _____
Age: _____ years _____ months Sex: M / F

Name of child's parent or legal guardian who will accompany the child to and from PDI and will be available during the treatment and postoperatively: _____
Phone number on day of treatment: _____
Reason for Treatment: _____
Has your child had any of the following? Check the appropriate box. If "yes" then specify.

Yes	No		Comments
☐	☐	Any recent COVID positive tests? What was the date?	_____
☐	☐	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 phlegm	_____
☐	☐	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?	

Name of Pediatrician _____ Phone number: _____
Any specific 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: _____

STICKER

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PDI Pediatric Anesthesia Questionnaire

Nombre de su hijo: _____

Edad: _____ años _____ meses Sexo: M / F

Nombre del padre o tutor legal que acompañará al paciente que estara disponible durante y después del tratamiento?:

_____

Numero de teléfono: _____Teléfono (el día de la cirugía, p. ej. celular o pager _____

motivo de la cita: _____

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

Si	No		Comments
☐	☐	¿Alguna prueba reciente positiva de COVID? ¿Cuál fe la fecha?	_____
☐	☐	¿Se ha sometido a alguna cirugía previa?	_____
☐	☐	Ha tenido problemas con la anestesia? ¿Algún pariente consanguíneo del paciente ha tenido problemas con la anestesia, incluida hipertermia maligna?	_____
☐	☐	¿Tiene o ha tenido algún problema medico?	_____
☐	☐	¿Su hijo toma o ha tomado recientemente algún medicamento (con y sin receta)?	_____
☐	☐	¿Ha usado corticosteroides (tales como cortisona o predisona) dentro del ultimo ano, incluidos tratamientos respiratorios?	_____
☐	☐	¿Ha usado algún dispositivo o maquina medica?	_____
☐	☐	¿Tiene alguna alergia (incluisas reacciones a los medicamentos o al latex)?	_____
☐	☐	¿Ha tenido algún problema al nacer, tales como nacimiento prematuro, uso de oxigeno o ventilación mecánica? Especifique:	_____
☐	☐	¿Ha estado expuesto a humo de cigarrillo? ¿Ha estado expuesto a las drogas?	_____
☐	☐	¿Recientemente tuvo algún resfrió o infección respiratoria? ¿Ha tenido tos con flemas?	_____
☐	☐	¿Tiene a ha tenido alguna dificultad para respirar, como silbido o asma?	_____
☐	☐	¿Tiene problemas de ronquido o de dejar de respirar durante el sueño?	_____
☐	☐	¿Tiene problemas de respiración entrecortada o fatiga excesiva al jugar, gatear, caminar, o correr? ¿Se “pone azul”?	_____
☐	☐	¿Se ha realizado alguna prueba o cirugía de corazón especial?	_____
☐	☐	¿Tiene antecedentes de problemas del corazón, soplo cardiaco, latidos cardiaco irregulares?	_____
☐	☐	¿Tiene antecedentes de convulsiones, epilepsia, o desvanecimiento?	_____
☐	☐	¿Tiene debilidad muscular, miopatía, o disfrogia muscular?	_____
☐	☐	¿Tiene alguna otra incapacidad física?	_____
☐	☐	¿Tiene antecedentes de diabetes? ¿Tiene problemas hormonales?	_____
☐	☐	¿El menor o algún pariente consanguíneo tienen problemas de sangrado a de coagulación?	_____
☐	☐	¿Tiene acidez estomacal o reflujo acido del estomago?	_____
☐	☐	¿Tiene antecedentes de ictericia o hepititis?	_____
☐	☐	¿Tiene algún problema riñones?	_____
☐	☐	¿Ha estado expuesto a la varicela en las ultimas dos semanas?	_____
☐	☐	¿Esta al día con las vacunas?	_____
☐	☐	¿Tiene algún diente flojo? ¿Tiene dientes astillados, rotos o faltantes, frenos o retenciones?	_____
☐	☐	¿Tiene algún otro problema medico?	_____
☐	☐	¿Tiene alguna preocupación especial con respecto a su hijo?	

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: _____