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 April 2017:

MEDICAL PROTOCOLS

- **Only refer:** Children with medical necessity as described by the state (See screening form 2); age 21 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: 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.

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)
   - ☐ Dental Screening Form page 2 – Medical Necessity or criteria indications for GA
   - ☐ Pediatric Anesthesia Questionnaire – Completed by parent/legal 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:**
   - 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
   - Overview of the surgery and pre-op steps (food, drink, medication, etc.)
   - Confirm if a dentist or anesthesiologist has discussed the procedure with the family
   - Contact family and remind them when it's time for their 3 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 or Rosa Bernal at 707-838-6560, or by e-mail at wendy@pdisurgerycenter.org or rosa@pdisurgerycenter.org.

To be filled out by referring dentist

Dental Surgery Referral Form

Please fax this form to PDI at 707-838-8464. If you are unable to fax, please email it to: referrals@pdisurgerycenter.org or mail 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) Down syndrome ☐ Autism ☐ Cerebral Palsy ☐
Developmentally delayed ☐ Other ☐ ____

I have read the information sheet about the fluoride varnish, and will allow a health professional to apply the varnish to my child's teeth. I understand this is a painless procedure that will only take a few minutes. NO YES

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

PDI Surgery Center:

DENTAL SCREENING Page 1 of 2

Required as of 9/1/15

Note to offices/clinics: PDI 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: ____

Treatment has been attempted: ☐YES ☐NO *** ***(See additional info needed on next page)***

X-Rays/Radiographs have been obtained: ☐YES ☐NO ☐Enclosed

Prophy has been done: ☐YES ☐NO

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

a b c d e f g h i j

t s r q p o n m l k

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

Tooth	Treatment Necessary

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.

To be filled out by referring dentist

PDI Surgery Center:

DENTAL SCREENING Page 2

Required as of 9/1/15

Patient Name: ___________________________________ **Date of Birth:** _________________

As of September 1, 2015, 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 *Intravenous* Sedation or General Anesthesia
Behavior modification and local anesthesia shall be attempted first, *conscious* sedation shall *then* be considered *if this fails or is not feasible based on the medical needs of the patient*.

If the provider *provides clear medical record* document*ation of* **both** number 1 and number 2 below, then the patient shall be considered for *intravenous* sedation or 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 *intravenous* sedation or 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 those statements above that are applicable to this patient. Please send any and all documentation of treatment attempted. There must be medical necessity for the patient to be seen under general anesthesia. You can either fill-out a narrative below or send us a copy of your chart notes. These patients have to be pre-authorized by their insurance in order to undergo dental treatment under general anesthesia. **Referring Dentist's Signature is required.**

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Dentist Signature and Date

Please add additional sheets if needed. Thanks!