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:

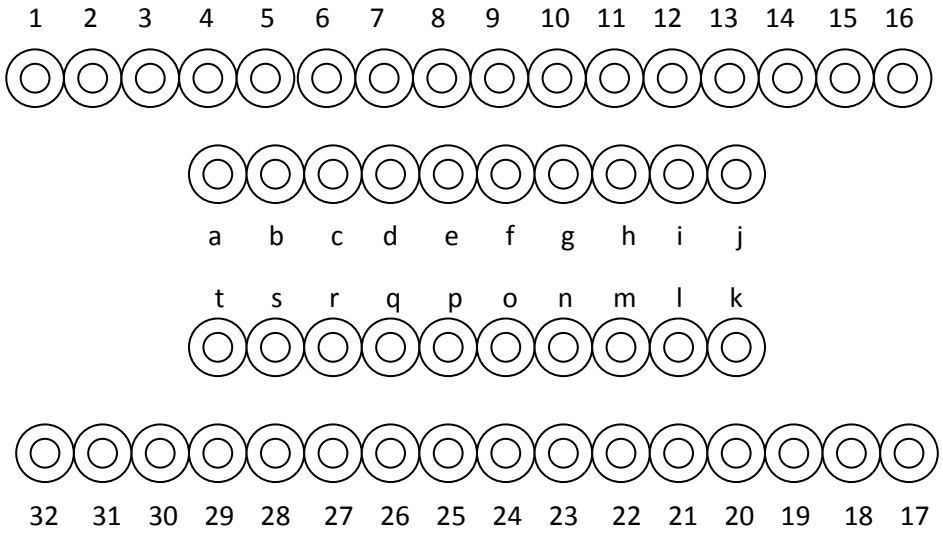
DENTAL SCREENING Page 1 of 2

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



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* documen*tation 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.**

_____

_____

_____

_____

_____

_____

Dentist Signature and Date

Please add additional sheets if needed. Thanks!

To be filled out by Patient's Physician

PDI Surgery Center
1380 19th Hole Drive
Windsor, CA 95492
Phone (707) 838-6560
Fax (707) 838-8464

PREOPERATIVE HISTORY AND PHYSICAL

DATE OF EXAM	TIME	NAME	DOB

CHIEF COMPLAINT

PRESENT ILLNESS

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

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

CURRENT MEDICATIONS:

PHYSICAL EXAM:

GENERAL APPEARANCE: ☐ Normal

	NORMAL	ABNORMAL FINDINGS/HX		NORMAL	ABNORMAL FINDINGS/HX
SKIN	☐		ABDOMINAL	☐	
HEAD	☐		GU SYSTEM	☐	
EYES	☐		RECTAL	☐	
ENT	☐		EXTREMITIES	☐	
NECK	☐		NEURO	☐	
CARDIAC	☐		LYMPH SYSTEM	☐	
BREAST	☐		PELVIC	☐	
CHEST	☐		OTHER	☐	

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

IMPRESSION:

PLAN:

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

Physician Signature _____

Print Name _____ Address _____

Phone _____

To be filled out by patient's family

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: _____

Para ser completado por la familia

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, especifique.

Si	No		Comentarios
☐	☐	¿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 esputo?	
☐	☐	¿Tiene a ha tenido alguna dificultad para respirar, como sibilancia o asma?	
☐	☐	¿Tiene problemas de ronquido o de dejar de respirar durante el sueno?	
☐	☐	¿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 renal?	
☐	☐	¿Ha estado expuesto a la varicela en las ultimas dos semanas?	
☐	☐	¿Esta al día con las inmunizaciones?	
☐	☐	¿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?	
☐	☐	¿Su hijo tiene alguna preocupación especial con respecto a la cirugía o la anestesia?	
☐	☐	¿Su hijo tiene algún juguete o manta especial que le sirva de consuelo? En tal caso, puede traerlo para la cirugía.	

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: _____