Endocrinology Consultation for Pediatric Dental Patients

To: _____ Date: _____

_____

_____

Re: Patient: _____ Nickname: _____ DOB: _____/_____/_____

Parent/Legal guardian: _____ Phone: _____

Summary of oral health findings and planned procedures following an oral examination on _____/_____/_____

Findings: ❑ Gingivitis ❑ Caries ❑ Pulpitis/pain ❑ Infection/abscess ❑ Traumatic injury ❑ Other _____

Planned invasive dental procedures: ❑ Subgingival cleaning ❑ Local anesthesia ❑ Restoration(s) ❑ Pulp therapy

❑ Extraction(s) (# of primary _____ permanent _____) ❑ Other _____

Behavior management plan (due to: ❑ fear/anxiety ❑ inability to cooperate ❑ complex dental needs ❑ patient safety)

❑ Nitrous oxide ❑ Protective stabilization ❑ Minimal to moderate sedation ❑ Deep sedation ❑ General anesthesia

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Please provide the following information to help minimize medical risks as this patient undergoes oral/dental care.

Endocrine diagnoses (*please attach a detailed medical summary if possible*): _____

_____

Comorbidities: _____

Medications: _____

Continuous glucose monitor (CGM): ❑ YES ❑ NO Insulin pump: ❑ YES ❑ NO

During invasive dental treatment, the patient's endocrine condition (*check all that apply*):

❑ does not pose a significant risk for adverse outcomes nor requires pre- or postprocedural interventions.

❑ poses a significant risk for other complication(s) and requires (*check all that apply; provide details below**):

- ❑ preoperative blood tests, medication, infusion, hydration, alteration in current medications, or other intervention.
- ❑ preoperative coordination.
- ❑ postoperative medication or other intervention.

Given this patient's medical history and planned dental procefures, do you have any concerns regarding:

use of in-office mild/moderate sedation (*dentist to specify agents/monitors/personnel*)? _____

_____ ❑ YES* ❑ NO

use /selection of postoperative analgesics? ❑ YES* ❑ NO

use of protective stabilization (restraint) for urgent procedures? ❑ YES* ❑ NO

If deep sedation/general anesthesia is medically necessary for this patient to receive dental care, which setting(s) would be appropriate (*check all that apply*)?

❑ Traditional dental office ❑ Free-standing ambulatory surgery center ❑ Community hospital ❑ Children's hospital

❑ Specific institution: _____

Does the patient have a need for concurrent procedures if undergoing sedation/general anesthesia? ❑ YES* ❑ NO

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* Please address risks, interventions, contraindications, and other considerations (*check* ❑ *if addressed in attachment or* ❑ *if continued on back of this page*):

_____

_____

_____

_____

_____

_____

_____

Have these pre-/peri-/postoperative recommendations been shared with the patient/parent? ❑ YES (on _____/_____/_____) ❑ NO

Contact for coordinating care: _____ Phone: _____

Print name: _____ Signature: _____ Direct phone: _____ Date: _____

Please return this form to: _____

_____