Hematology 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 (# 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

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

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

_____

Comorbidities: _____

Medications: _____ Indwelling venous access device? ❑ NO ❑ YES

During invasive dental treatment, the patient's hematologic condition (*check all that apply; provide details below**)

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

❑ poses a significant risk for bacteremia-induced infection that warrants perioperative antibiotic prophylaxis* (to be prescribed by the ❑ hematologist or ❑ dentist).

❑ poses a significant risk for other complication(s) and requires*

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

❑ perioperative coordination.

❑ postoperative medication or other intervention.

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

use of local anesthetic containing vasoconstrictor (epinephrine)? ❑ NO ❑ YES*

injection technique (eg, nerve block vs. infiltration)? ❑ NO ❑ YES*

use of inhaled nitrous oxide/oxygen analgesia/anxiolysis (up to a 1:1 ration) in an open system? ❑ NO ❑ YES*

use of in-office minimal/moderate sedation? (***dentist to specify*** agents/route; monitors/personnel): _____

_____ ❑ NO ❑ YES*

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

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? ❑ NO ❑ YES*

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

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_____

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_____

_____

Contact for coordinating care: _____ Phone: _____

Printed name: _____ Signature: _____ Direct phone: _____ Date: _____

Please return this form to: _____