Oncology Consultation for Pediatric Dental Procedures

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 _____

Minimally invasive procedures: ❑ Supragingival cleaning ❑ Orthodontics ❑ Other _____

Invasive procedures: ❑ Subgingival cleaning ❑ Restoration(s) ❑ Root canal 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 ❑ Moderate oral sedation ❑ Moderate/deep IV sedation ❑ General anesthesia

---

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

Oncology diagnosis including type, stage, completed treatment, planned therapy (❑ *if summary is attached*): _____

_____

_____

Comorbidities: _____ Central venous access device: ❑ YES ❑ NO

Medications (❑ *if list attached*): _____

When this individual undergoes invasive dental treatment, the patient's oncology therapy (*check all that apply*):

- ❑ 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 antibiotic prophylaxis (to be prescribed by the ❑ oncologist or ❑ dentist). ***Please provide parameters/details below* or on a separate page.***
- ❑ poses a significant risk for other complication(s) and requires:
  - ❑ preoperative blood tests, medication, transfusion.*
  - ❑ preoperative medications to be ceased.*
  - ❑ postoperative medication or other intervention.*

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

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

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

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

_____ ❑ 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

---

* Please address risks, interventions, contraindications, and other considerations (including timing and laboratory parameters): _____

_____

_____

_____

_____

_____

_____

Contact for coordinating care: _____ Phone: _____

Signature: _____ Direct phone: _____ Date: _____

Please return this form to: _____

_____