

Medical Clearance & Sedation Clearance Form for Patients with Special Healthcare Needs

Required documentation for CDT D9997 Dental Case Management Patients with Special Healthcare Needs

Request Date _____

Member Name:				Phone:		
Address:				City:		
TennCare ID:		Sex at birth:		Age:		DOB:
Qualifying Diagnosis						
Additional Diagnoses:						
Allergies:						

Dental Office:				Dentist:		
Address:				City:		
Office Phone:		Fax:		Email:		

Medical Office:				Physician:		
Address:				City:		
Office Phone:		Fax:		Email:		

Reasons for request: (check all that apply)	
<input type="checkbox"/>	Failure of effective communication techniques and inability for immobilization (patient may be a danger to self or staff)
<input type="checkbox"/>	Patient has acute situational anxiety due to immature cognitive functioning
<input type="checkbox"/>	Patient is uncooperative due to certain physical or mental compromising conditions
<input type="checkbox"/>	Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation
<input type="checkbox"/>	Use of local anesthesia to control pain failed or was not feasible based on the medical needs of the patient
<input type="checkbox"/>	Use of conscious sedation, either inhalation or oral, failed or was not feasible based on the medical needs of the patient
<input type="checkbox"/>	Other (please list)

<i>Your patient is being scheduled for dental procedures that may require the administration of local anesthesia. He/she may also require the administration of IV sedation or general anesthesia. Please review the clearance requested, the reasons checked below and complete the Primary Care Provider Response section to allow if it is safe for the patient.</i>	
Dental Provider, please check/circle the items below: <ul style="list-style-type: none"> <input type="checkbox"/> Local Anesthesia (2% Xylocaine 1X100,000 epinephrine) <input type="checkbox"/> Nitrous Oxide / Oxygen Analgesia <input type="checkbox"/> Oral Sedation 	<ul style="list-style-type: none"> <input type="checkbox"/> IV Sedation <input type="checkbox"/> General Anesthesia in Hospital or Surgi-Center

Primary Care Provider Response: Check all that apply	
<input type="checkbox"/>	No contraindications for general anesthesia for dental procedure
<input type="checkbox"/>	No special precautions needed for dental treatment
<input type="checkbox"/>	No Prophylactic antibiotics needed
<input type="checkbox"/>	Agree with dentist's medical or behavioral diagnosis as indication for: (circle one)

	Nitrous Oxide Analgesia	Oral Sedation	IV Sedation	General Anesthesia
	Comments/Other:			
	Physician Signature:	Printed Name:	Date:	