FORMS

1. **BHSF FORM 9-M**
2. **PEDIATRIC CONSCIOUS SEDATION FORM**
3. **TEMPOROMANDIBULAR JOINT (TMJ) FORM**

BHSF Form 9-M
Issued 12/03

Medicaid Program

Referral For Pregnancy Related Dental Services

(Must Be Completed By The Medical Professional Providing Pregnancy Care)

Part I: All Items Must Be Complete

Name of Patient:_____

Street Address:_____ City:_____ Zip Code:_____

Medicaid Recipient ID #: _____

Estimated Date of Delivery (MM/DD/YYYY): _____

Part II: Check (☑) All Conditions That Apply

- ☐ Bleeding Gums
- ☐ Swollen, puffy gums
- ☐ Loose teeth
- ☐ Teeth with obvious decay
- ☐ Teeth that appear longer
- ☐ Pain associated with teeth or gums
- ☐ Bad breath odor that does not go away with normal brushing
- ☐ Spaces between the teeth that were not there before
- ☐ Inability to chew or swallow properly
- ☐ Tender gums that bleed when brushing

Are there any medical or perinatal complications that the dentist should be aware of prior to the delivery of dental services? ☐ YES ☐ NO If **yes**, please describe below:

_____

_____

Is pre-medication or other medication required prior to dental treatment? ☐ YES ☐ NO
(If **yes**, please attach a photocopy of the prescription.)

Part III: Check (☑) Any Services That Are Contraindicated

- ☐ Local Anesthetic
- ☐ Radiograph(s)
- ☐ Teeth Cleaning
- ☐ Restoration(s)
- ☐ Gum Treatment – Ultrasonic Cleaning and/or Scaling Below the Gum Line
- ☐ Extraction(s)

Part IV: Please include other comments and/or recommendations below:

_____

_____

I have confirmed the pregnancy with diagnostic testing for the above-named patient.

_____	_____	( ) _____	_____
Medical Professional Signature **(Required)**	Provider Type & License #	Office Telephone #	Date

To locate a Medicaid enrolled dentist, you may contact the Medicaid Referral Assistance Hotline toll-free at 1-877-455-9955.

PEDIATRIC DENTISTRY CONSCIOUS SEDATION

Child's Name _____ **Sex** ____ **Race** ____ **Date** _____

Child's Medicaid ID# _____

Weight _____ lb. _____ kg. **Operating Dentist(s)** _____

Age _____ yr. _____ mo. **Assistants** _____

Preoperative Health Evaluation _____ **ASA 1** ☐ **2** ☐ **3** ☐ **4** ☐

NPO Status _____

Preoperative Behavior Evaluation _____

Frankl Scale: ☐ 1 – definitely negative ☐ 3 – positive **North Carolina Scale**: Head Movement ☐ Crying ☐

☐ 2 negative ☐ 4 – definitely positive Physical Resistance ☐ Hands ☐ Legs ☐

Restraints: Papoose Board ☐ Pediwrap ☐ Velcro Seatbelts ☐ Mouth Prop ☐ Other: _____

Preprocedural Drug: _____ Route: _____ Dose (mg): _____ Time: _____ Administered by: _____

Sedation Medication Drug: _____ Route: _____ Dose (mg): _____ Time: _____ Administered by: _____

Route of Administration ☐ Oral ☐ Intramuscular ☐ Submucosal ☐ Other _____

Monitoring Devices ☐ B.P. Cuff ☐ P.C. Steth ☐ Dynamap ☐ Pulse Oximeter Other: _____

MONITOR/AGENT	DOSE	TIME→ (Base Line)														
Respiration rate/min.																
Pulse rate/min.																
Oxygen Saturation																
Blood Pressure Systolic																
Diastolic																
2% Xylo. ____ epi. (4.0 mg/kg)	mg.															
Nitrous Oxide (N_2O-02%)																
Hydroxyzine (Vistaril) (1.0-2.0 mg/kg)	mg.															
Promethazine (Phenergan)(1.0mg/kg)	mg.															
Meperidine (Demerol) (1.0-2.0 mg/kg)	mg.															
Diazepan (Valium) (0.25-0.5 mg/kg)	mg.															
Midazolam (Versed) (0.3-0.7 mg/kg)	mg.															
Chloral Hydrate(Noctec) (25-50mg/kg)	mg.															
Naloxone (Narcan) (0.01 mg/kg)	mg.															
Flumazenil (Romazicon) (0.01 mg/kg)	mg.															

NOTE: ATTACH PRINTOUT OF MONITORING DEVICE, IF AVAILABLE.

Treatment: Time Started: _____ Completed: _____ Elapsed time: _____ hr. _____ min.

LEVEL OF SEDATION

- ☐ No behavioral change
- ☐ Sedated but disruptive when stimulated
- ☐ Sedated but responsive to verbal command
- ☐ Sedated – slept but responsive to verbal command
- ☐ Sedated – slept, responsive only to physical stimulation
- ☐ Slept and unresponsive to verbal or physical stimulation
- ☐ Unconscious and unresponsive
- ☐ Other

EFFECTIVENESS OF SEDATION

☐ Ineffective ☐ Effective ☐ Very Effective ☐ Over-Sedated

SIDE EFFECTS

☐ Nausea ☐ Vomiting ☐ Respiration Depression

☐ Vertigo ☐ Headache ☐ Prolonged Recovery

Postoperative Course and Discharge Evaluation

☐ Alert ☐ Talking/Crying ☐ Ambulatory

☐ CV Stable ☐ Airway Stable ☐ Sit Unaided

Disposition: _____

Signature: _____ **Time of Discharge:** _____

TMJ SUMMARY

Patient's Name:_____ Age:_____ M F

Recipient Number: _____

< The items written in small print, in each category are not inclusive and should be used only as guides>

Chief Complaints:

Facial Pain: headaches. TMJ pain. TMJ sounds. cervical pain. oral pain. dental pain. decrease in jaw ROM. ringing in ears. jaw locking. closed or open. duration

Clinical Findings:

Palpation of: TMJ. masticator muscles. cervical muscles: functional manipulation: jaw and neck ROM: TMJ sounds: occlusion

Radiographic Findings:

Impressions:

Myofacial Pain: masticatory muscles. cervical muscles. TMJ capsules. TMJ disc displacement or dislocation. Hyper-mobility. osteoarthritis. headaches. myofacial tension. missing teeth. malocclusion. chronic pain. etc.

Etiology:

Trauma. Bruxism. Missing teeth. malocclusion. etc.

Recommendations:

If splints are requested please state if it will be a hard or soft splint.