



## Level of Care Support for People with Disabilities

Going to the dentist can be stressful. If a person has a disability they might need help deciding what kind of dentist they need. Most people with disabilities will need no extra supports except maybe a little more time and understanding. Other people with disabilities may need medication to complete a visit or help to safely relax to allow for dental services.

**There is a dentist for everyone.**

**We call this “Levels of Care”.**

You and/or your family members or support staff can make decisions about what is best for you. Your dentist or dental hygienist can help you decide what level of care you need. Your primary care doctor can help as well. Sometimes people can have a routine service (like cleaning) with no extra help but, may need a higher level of care for other services. It all depends on you or the needs of the person you support.

## **There is help available.**

Your primary care doctor can help answer questions, as can your dentist or dental hygienist. Your Medical Assistance (Medicaid) or Managed Care Organization staff can also help. There are some great tools for people who would like to work on needing less support in the dental office, such as de-sensitization and practicing what will happen during a dental visit, before it occurs. Information about levels of care and how to have successful dental visits are available at ACHIEVA's website. (below)

Being prepared for the dental appointment can make the appointment less stressful. Please find the pre-visit form on the next pages, which will help you decide what level of care you or the person you support needs.

Your Medical Assistance (Medicaid) or Managed Care Organization staff have been trained on levels of care and can help you to identify a dentist who provides the level of care you need.

**\* Please send the pre-visit form to your dentist before the visit or bring it with you.**

These forms may be printed and completed or downloaded to your computer and completed. Currently available at these websites:

- The Pennsylvania Health Care Quality Units  
<http://achieva.nurelm.com/services.jsp?pagelid=2161392240601293465379274>  
ACHIEVA website - Look under HCQU contact lists
- ACHIEVA  
[www.achieva.info](http://www.achieva.info)

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## Dental Pre Visit Form Special Needs

*Instructions: Please complete this form for yourself or for the special needs person you are supporting.*

*Print or complete on the computer. USE TAB TO GO TO NEXT AVAILABLE SPACE WHEN ENTERING INFORMATION.*

Section I: Patient Demographics	
Name	Home Phone
Address	Date of Birth
Type of Residence (check which is applicable)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Family Home <input type="checkbox"/> Residential Program <input type="checkbox"/> Family/Assisted Living <input type="checkbox"/> Independent/Own Home <input type="checkbox"/>	Agency Address
Agency Name	Agency Phone

<i>Emergency Contact Information</i>	
Emergency Contact Name	Relationship to Patient (title, if applicable)
Address	Telephone
Legal Guardian <input type="checkbox"/> Yes <input type="checkbox"/> No	Legal Guardian Name
	Legal Guardian Phone

<i>Insurance Information</i>	
Name of Insured	Date of Birth
Address	Relationship to Patient
Social Security Number	Employer Name
Medical Assistance/Access Number	Managed Care Organization <i>company name and number</i>
Private Insurance <i>company name and number</i>	Medicare (Managed Care Organization) <i>company name and number</i>

*Primary Care Physician*

Primary Care Physician Name	Telephone Number	Address

*Previous or Referring Dentist*

Dentist Name	Telephone Number	Address

**Section II: Medical Diagnoses**

**Check all that apply**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Allergies, specify  | <input type="checkbox"/> Hemophilia                         | <input type="checkbox"/> Mental Illness: specify diagnosis |
| <input type="checkbox"/> Latex Allergy   | <input type="checkbox"/> Hepatitis B                        | <input type="checkbox"/> Mouth Pouching                    |
| <input type="checkbox"/> Alzheimer's Disease   | <input type="checkbox"/> High blood pressure                | <input type="checkbox"/> Musculoskeletal concerns: specify |
| <input type="checkbox"/> Aspiration Precautions  | <input type="checkbox"/> History of heart valve replacement | <input type="checkbox"/> Contractures                      |
| <input type="checkbox"/> Autism Spectrum   | <input type="checkbox"/> History of joint replacement       | <input type="checkbox"/> Rigidity                          |
| <input type="checkbox"/> Blood Disorder  | <input type="checkbox"/> HIV Positive                       | <input type="checkbox"/> Spasticity                        |
| <input type="checkbox"/> Cancer Treatment  | <input type="checkbox"/> Hyperactive gag reflex             | <input type="checkbox"/> Special positioning needs         |
| <input type="checkbox"/> History <input type="checkbox"/> Current                                      | <input type="checkbox"/> Hyperactive emetic reflex          | <input type="checkbox"/> Uncontrolled body movements       |
| <input type="checkbox"/> Chemo therapy   | <input type="checkbox"/> Incontinence                       | <input type="checkbox"/> PICA                              |
| <input type="checkbox"/> Radiation   | <input type="checkbox"/> Kidney Disease                     | <input type="checkbox"/> Previous surgery: explain         |
| <input type="checkbox"/> Cerebral Palsy  | <input type="checkbox"/> Liver Disease                      | <input type="checkbox"/> Rumination                        |
| <input type="checkbox"/> Diabetes ( <input type="checkbox"/> IDDM or <input type="checkbox"/> AODM II) | <input type="checkbox"/> Lung Disease                       | <input type="checkbox"/> Seizure Disorder                  |
| Does the patient require:  | <input type="checkbox"/> Mental Retardation: Level          | <input type="checkbox"/> Sexually Transmitted Disease      |
| <input type="checkbox"/> Insulin Injections <input type="checkbox"/> Oral medication                   | <input type="checkbox"/> Mild                               | <input type="checkbox"/> Smoking                           |
| <input type="checkbox"/> Down Syndrome   | <input type="checkbox"/> Moderate                           | <input type="checkbox"/> Tuberculosis                      |
| <input type="checkbox"/> Dysphagia (swallowing problems)   | <input type="checkbox"/> Severe                             | <input type="checkbox"/> Tongue thrusting                  |
| <input type="checkbox"/> GERD/reflux   | <input type="checkbox"/> Profound                           |  |
| <input type="checkbox"/> Heart related conditions  |   |  |

**Section III: General Functioning**

Choose the best matching level, check boxes

**A. Speech/Communication**

- Completely verbal, clearly expresses thoughts
- Somewhat verbal, sentences incomplete
- Somewhat verbal, uses signs or devices
- Primarily nonverbal, uses sounds, gestures, or signs
- Nonverbal, uses pictures
- Nonverbal, expresses with face and behavior
- Nonverbal, unable to communicate thoughts

Understands basic one step directions?  Yes  No

**B. Hearing**

- Normal
- Impaired (uses a hearing aide  Yes  No)
- Deaf

**C. Vision**

- Normal
- Impaired (uses glasses  Yes  No)
- Blind

**D. Mobility**

- Completely mobile, little or no assistance
- Able to walk, but unsteady
- Able to walk, needs assistance with steps
- Physical assistance (e.g., sighted guide)
- Mechanical assistance, cane, walker, crutches
- Needs mechanical and physical assistance
- Non-ambulatory, can operate a wheelchair
- Non-ambulatory, completely dependent

**E. Eating**

- Eats a regular diet
- Eats a soft or pureed diet
- Eats a liquid diet only
- Has feeding tube or g tube
- Reason for dietary modification:

**Section IV: Behavioral Approaches**

**A.) Describe dental appointment behaviors based upon past experience**

- |  |   |
|--|---|
| <input type="checkbox"/> Cooperative under all circumstances   | <input type="checkbox"/> Resists contact                            |
| <input type="checkbox"/> Cooperative under most circumstances<br>Please describe what the patient can or cannot tolerate | <input type="checkbox"/> Refuses to open mouth, requires mouth prop |
| <input type="checkbox"/> Fearful and tactile defensive   | <input type="checkbox"/> Combative                                  |
| <input type="checkbox"/> History of biting   | <input type="checkbox"/> Hyperactive/short attention span           |
| <input type="checkbox"/> Lip biting following anesthesia   | <input type="checkbox"/> Tremors                                    |
|  | <input type="checkbox"/> Vocal outbursts                            |
|  | <input type="checkbox"/> Waiting room behavior is disruptive        |

**B.) Describe strategies that are effective**

- |  |   |
|--|---|
| <input type="checkbox"/> Calm voice                      | <input type="checkbox"/> Positive reinforcement/Rewards (specify what is rewarding)             |
| <input type="checkbox"/> Directive                       | <input type="checkbox"/> Demonstration of appointment activities                                |
| <input type="checkbox"/> Distraction                     | <input type="checkbox"/> Mechanical immobilization/ Protective stabilization (light restraints) |
| <input type="checkbox"/> Humor                           | <input type="checkbox"/> Other behavior management techniques                                   |
| <input type="checkbox"/> Pre-medication to relax patient |   |

**C.) Describe what relaxes the patient**

D.) Will patient easily open their mouth for tooth brushing/oral hygiene?

Yes  No

E.) What is the patient's reaction to needles?

### Section V: Dental Specific Needs

1. Patient requires assistance to use the dental chair.  Yes  No
2. Patient needs physical support in the dental chair.  Yes  No
3. Patient cannot use a dental chair.  Yes  No
4. Is the patient currently experiencing pain, swelling, or redness?  Yes  No
5. Is the patient without teeth?  Yes  No
6. Is the patient missing some teeth?  Yes  No
7. Does the patient have dentures?  Yes  No
8. Would he/she tolerate dentures if teeth need replacement?  Yes  No

9. What is the patient's oral hygiene routine? *circle all that apply*

Toothbrush    floss    electric    toothbrush    water pic,    cloth/sponge    other tool

10. Can patient brush his/her own teeth? *circle one*

With no assistance

With some assistance

Needs total assistance

11. Can patient rinse mouth well?  Yes  No
12. Does the patient have a history of oral or facial trauma?  Yes  No
13. Has sedation been required for dental care in the past?  Yes  No
14. Does the patient require any medications prior to dental treatment?  Yes  No

If yes, specify

- Nitrous Oxide (laughing gas)
- Oral sedation (medication)
- IM sedation
- IV sedation
- General Anesthesia

15. Has the patient required physical restraints (protective stabilization/mechanical immobilization) to accomplish dental care in the past?  Yes  No

16. Will it be necessary to use protective stabilization for this person to receive dental care?  Yes  No

17. Most recent general dental visit: Date

18. How often does patient receive dental check ups?

19. Type of treatment received at the most recent visit (check all that apply):

- Screening (exam)
- Periodontal (cleaning)
- Restorative (filling)
- Surgery (to jaw, gums, mouth)
- Extraction (tooth pull)
- Orthodontics (braces)
- Gum treatment

*Please attach documentation of previous dental visits*

## Section VI: Proposed level of Dental Care

Select level of care based upon previous dental experiences or previous dental assessments. Use chart below.

Level I     
  Level II     
  Level III     
  Level IV

Level of Care		Level of Care
<b>Level 1 Care</b>	The special needs of the patient do not require any special modalities other than time to provide the dental care. Dentists providing level I care <u>may</u> use the behavior management techniques.	Community-based Care for people who are cooperative and are not fearful of the dentist, who may require little or no assistance to complete comprehensive dentistry. Patient may need some pre medication and/or local anesthesia.
<b>Level 2 Care</b>	The special needs of the patient with some level of cooperation requires anxiolytic (chemical) support <u>or</u> desensitization and/or behavioral management to be successfully treated. (This includes nitrous oxide or analgesics)	Community-based care for people who are generally cooperative during a dental visit. Patient may need some behavioral support, desensitization, and/or nitrous oxide/oxygen.
<b>Level 3 Care</b>	The special needs of the patient are not responsive to level 1 or 2 care modalities and/or historically has been unsuccessful in treatment attempts at level 1 or 2, and therefore, requires IV sedation (pharmacological treatment) in order to be successfully treated.	Community or specialty clinic-based care for people who are historically not successful under level 1 or 2. These patients require a level of sedation above level 2, but not anesthesia or deep sedation, due to behaviors and/or medical complexity.
<b>Level 4 Care</b>	The special needs of the patient are not responsive to levels 1, 2 or 3 care and/or historically have been unsuccessful in treatment attempts at levels 1, 2 or 3, and/or the treatment required is so extensive and /or urgent that the patient will require anesthesia for successful treatment.	Patient cannot complete dental visit in a typical community practice due to resistant or difficult behaviors or medical complexity. Person will need specialized setting, ambulatory surgical center or hospital to complete comprehensive dentistry using deep conscious sedation or general anesthesia.

2/12/09

Where has the patient received care in the past?

Dental Office     
  Specialty Clinical     
  Hospital

Does this person require the level of care previously received or could the patient use less restriction?

Name of person completing this form (printed)

Signature

Date

Title

Phone Number

Attach current physical exam and list of medications with last visit form