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 desensitization 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?pageId=2161392240601293465379274
  ACHIEVA website - Look under HCQU contact lists

- ACHIEVA
  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

<table>
<thead>
<tr>
<th>Name</th>
<th>Home Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Date of Birth</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of Residence (check which is applicable)</th>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Residential Program</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family/Assisted Living</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Independent/Own Home</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agency Address</th>
<th>Agency Phone</th>
</tr>
</thead>
</table>

**Emergency Contact Information**

<table>
<thead>
<tr>
<th>Emergency Contact Name</th>
<th>Relationship to Patient (title, if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Telephone</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Legal Guardian</th>
<th>Yes</th>
<th>No</th>
<th>Legal Guardian Name</th>
<th>Legal Guardian Phone</th>
</tr>
</thead>
</table>

**Insurance Information**

<table>
<thead>
<tr>
<th>Name of Insured</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Relationship to Patient</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Security Number</th>
<th>Employer Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Medical Assistance/Access Number</th>
<th>Managed Care Organization</th>
<th>company name and number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Private Insurance</th>
<th>Medicare (Managed Care Organization)</th>
<th>company name and number</th>
</tr>
</thead>
</table>
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

- Allergies, specify
  - Latex Allergy
  - Alzheimer's Disease
  - Aspiration Precautions
  - Autism Spectrum
  - Blood Disorder
  - Cancer Treatment
  - History
  - Current
  - Chemo therapy
  - Radiation
  - Cerebral Palsy
  - Diabetes (IDDM or AODM II)
  - Does the patient require:
    - Insulin injections
    - Oral medication
  - Down Syndrome
  - Dysphagia (swallowing problems)
  - GERD/reflux
  - Heart related conditions

- Mental Illness: specify diagnosis
  - Hemophilia
  - Hepatitis B
  - High blood pressure
  - History of heart valve replacement
  - History of joint replacement
  - HIV Positive
  - Hyperactive gag reflex
  - Hyperactive emetic reflex
  - Incontinence
  - Kidney Disease
  - Liver Disease
  - Mental Retardation: Level
  - Mild
  - Moderate
  - Severe
  - Profound
  - Mental Illness: specify diagnosis
  - Mouth Pouching
  - Musculoskeletal concerns: specify
  - Contractures
  - Rigidity
  - Spasticity
  - Special positioning needs
  - Uncontrolled body movements
  - PCA
  - Previous surgery: explain
  - RUMINATION
  - Seizure Disorder
  - Sexually Transmitted Disease
  - Smoking
  - Tuberculosis
  - Tongue thrusting

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 sounds 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. Seizure Disorder
  - Seizure Disorder

C. Sexually Transmitted Disease
  - Sexually Transmitted Disease

D. Smoking
  - Smoking

E. Tuberculosis
  - Tuberculosis

F. Tongue thrusting
  - Tongue thrusting
### 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
- Cooperative under all circumstances
- Cooperative under most circumstances
  - Please describe what the patient can or cannot tolerate
- Fearful and tactile defensive
- History of biting
- Lip biting following anesthesia
- Resists contact
- Refuses to open mouth, requires mouth prop
- Combative
- Hyperactive/short attention span
- Tremors
- Vocal outbursts
- Waiting room behavior is disruptive

#### B.) Describe strategies that are effective
- Calm voice
- Directive
- Distraction
- Humor
- Pre-medication to relax patient
- Positive reinforcement/Rewards (specify what is rewarding)
- Demonstration of appointment activities
  - Mechanical immobilization/Protective stabilization
  - (light restraints)
- Other behavior management techniques

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

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#### 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?  
   [ ] 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.

<table>
<thead>
<tr>
<th>Level of Care</th>
<th>Level of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I</td>
<td>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.</td>
</tr>
<tr>
<td>Level II</td>
<td>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.</td>
</tr>
<tr>
<td>Level III</td>
<td>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.</td>
</tr>
<tr>
<td>Level IV</td>
<td>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.</td>
</tr>
</tbody>
</table>

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