Corewell Health

Supplemental Form to be Completed for Cases that Meet Dental Level 2 Criteria:

MRN: ______________________________

Patient Name: ____ **DOB:** ______________________________

Dental Provider: ____ **Dental Office:** _______________________

Primary Office Contact Person: ______________________________ **Phone:** ____________________________

Note: Please note that for anything besides a Level 1 Case, you must submit the below completed form, a narrative (describing why treatment is needed at HDVCH), clinical photos, and radiographs, etc)

CRITERIA FOR FULL MOUTH ORAL REHAB UNDER GENERAL ANESTHESIA	
Part 1: Age of Patient At Time of Exam	
Less than 4 years old	☐
4-5 years	☐
6-7 years	☐
8 years and older	☐
Part 2: Treatment Requirements (Carious and/or Abscessed Teeth)	
1-2 Teeth or 1 Sextant	☐
3-4 Teeth or 2-3 Sextants	☐
5-8 Teeth or 4 Sextants	☐
9+ teeth in 5-6 Sextants	☐
Part 3: Additional Factors (Require Narrative Below)**	
Presence of oral pathology other than caries requiring surgical intervention (i.e. impacted mesiodens, wisdom tooth EXT, etc)	☐
Failed Oral Conscious Sedation	☐
Failed Nitrous Oxide	☐
Not approved for outpatient anesthesia due to medical complexity	☐
Medically Compromising or Handicapping Condition	☐
Behavior of Patient: Definitely Negative – unable to complete treatment in office due to lack of physical or emotional maturity and/or disability ***Requires narrative fully describing patient's behavior	☐
Minimally Invasive Care Utilized (SDF, Hall Technique, etc)	☐

Patient Medical History: ____

Current Medications: ____

Narrative (required if checked box in Part 3): ____

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X-rays: ☐ Attached ☐ Not Attached **Clinical Photos:** ☐ Attached ☐ Not Attached

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Case Review Status: ☐ **Approved** ☐ **Denied** **Date:** ___________ **Initials:** __________

If your case has been approved, proceed with submitting a case request with required date, no additional forms needed.
Approved request, submit case request with required date, no additional formed needed.