



REFERRAL DETAILS

REFERRING OFFICE

DATE OF BIRTH

PATIENT NAME

E-MAIL

PATIENT'S PHONE NUMBER

INSURANCE NAME / NUMBER

MEDICAL NECESSITY FOR REFERRAL

Based on my clinical evaluation and professional judgment, I believe this patient cannot be safely and effectively treated in a conventional dental office utilizing accepted behavior guidance techniques and that referral for evaluation for comprehensive dental rehabilitation under general anesthesia is medically appropriate due to the following:

★ Starred sections must be completed — patient-specific detail is what substantiates medical necessity.

★ CLINICAL FINDINGS check all that apply

- ☐ Young age, developmental immaturity, and/or inability to understand or cooperate sufficiently for safe dental treatment.
- ☐ Severe dental fear, anxiety, uncooperative and/or combative behavior (Frankl 1 and/or 2) preventing safe and effective completion of treatment.
- ☐ Conventional behavior guidance techniques (Tell-Show-Do, positive reinforcement, distraction, parental presence, etc.) and/or nitrous oxide/sedation were unsuccessful, not tolerated, contraindicated, or not clinically appropriate.
- ☐ Extensive dental disease requiring comprehensive dental rehabilitation (multiple teeth and/or quadrants with anticipated restorative, pulp, surgical, and/or other comprehensive dental treatment).
- ☐ Pain, infection, swelling, pulpal pathology, abscess, cellulitis, and/or other urgent dental condition requiring timely treatment.
- ☐ Medical, developmental, behavioral, neurological, sensory, and/or other special healthcare needs substantially affecting the patient's ability to safely complete dental treatment.

↳ If so, diagnosis/condition (if applicable)

★ PATIENT-SPECIFIC FINDINGS in the referring dentist's own words

PATIENT-SPECIFIC FINDINGS SUPPORTING MEDICAL NECESSITY FOR GENERAL ANESTHESIA

★ TEETH WITH CLINICAL SIGNS OF CARIES please circle

SEXTANT I						SEXTANT II						SEXTANT III					
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16		
A B C D E F G H I J																	
T S R Q P O N M L K																	
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17		
SEXTANT VI						SEXTANT V						SEXTANT IV					

★ X-RAYS

- ☐ Taken (please provide to the patient or e-mail it to OR@littlegreens.org) ☐ Not possible due to uncooperative behavior

REFERRING DENTIST CERTIFICATION

I certify that the information documented above accurately reflects my clinical findings and professional judgment at the time of referral. I believe this patient cannot be safely and effectively treated in a conventional dental office utilizing accepted behavior guidance techniques and that referral for evaluation for comprehensive dental rehabilitation under general anesthesia is medically appropriate. I understand that the treating pediatric dentist will confirm the diagnosis, treatment needs, medical necessity, and appropriateness of treatment under general anesthesia prior to proceeding on the day of procedure.

REFERRING DENTIST

SIGNATURE

DATE

SURGICAL CENTER LOCATIONS

South Brooklyn Health • 2601 Ocean Pkwy, Brooklyn, NY 11235

EMU Health • 83-40 Woodhaven Blvd, Glendale, NY 11385

EMU Health at Advanced Surgery Center • 150 S. Pearl River St., Pearl River, NY 10965

Queens Surgical Center • 3636 Main St., Flushing, NY 11354

Kings Surgical Center • 1807 66th St., Brooklyn, NY 11204

Thank you
for your referral!

PHONE 917-979-6579
FAX 917-979-2853
EMAIL OR@littlegreens.org
WEB littlegreens.org

