



KAISER
PERMANENTE®

DENTAL THERAPY UNDER GENERAL ANESTHESIA – Dental Documentation

PATIENT'S NAME

MEDICAL RECORD NUMBER

MM	DD	YYYY
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DATE OF REQUEST

❖ To be completed by requesting dentist

1. Please describe the specific dental treatment required for this Kaiser Permanente member and the reason and rationale for your request, including any failed attempts at conscious sedation or behavior modification:

MANAGEMENT METHODS ATTEMPTED

- ☐ Show-Tell-Do Method Number of Attempts: _____ ☐ Nitrous Oxide
☐ Oral Sedation ☐ Local Anesthetic
☐ Other: _____

2. Does the treatment described above always require IV sedation or general anesthesia? ☐ YES ☐ NO

3. Does the patient require IV Sedation or General Anesthesia? ☐ IV Sedation ☐ General Anesthesia

4. Please indicate the reason for this request; check all that apply:

- ☐ Use of local anesthesia to control pain failed or was not feasible based on the medical needs of the patient.
- ☐ Use of conscious sedation, either inhalation or oral, failed or was not feasible based on the medical needs of the patient.
- ☐ Use of effective communicative techniques and the inability for immobilization (patient may be dangerous to self or staff) failed or was not feasible based on the medical needs of the patient.
- ☐ Patient requires extensive dental restorative or surgical treatment that cannot be rendered under local anesthesia or conscious sedation.
- ☐ Patient has acute situational anxiety due to immature cognitive functioning.
- ☐ Patient is uncooperative due to certain physical or mental compromising conditions.

Please note: To proceed with the dental care and general anesthesia the appropriate narrative and all supporting documentation must be included in the client's dental chart. The client's chart must be available for review by representatives of The Permanente Medical Group, Inc.

By signing below I attest to the accuracy and completeness of the information provided on this form. I agree to provide the patient's records, if requested to substantiate the patient's medical necessity.

PERFORMING DENTISTS SIGNATURE:

DATE:

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PRINTED NAME:

LICENSE NUMBER

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Please fax completed form to _____ Attention: _____ or email to _____@kp.org