INTERNAL DENTAL INTAKE ASSESSMENT & REFERRAL

Date___________ Initials__________
□ Add to Excel Referral Log
□ Enter Demo, Enroll & Notes in CARES
□ Create/Move Folder in Patient File Cabinet (V drive)
□ Scan, Label, Add to Printed Faxes folder
□ Add to Elig Screen Dental Folder

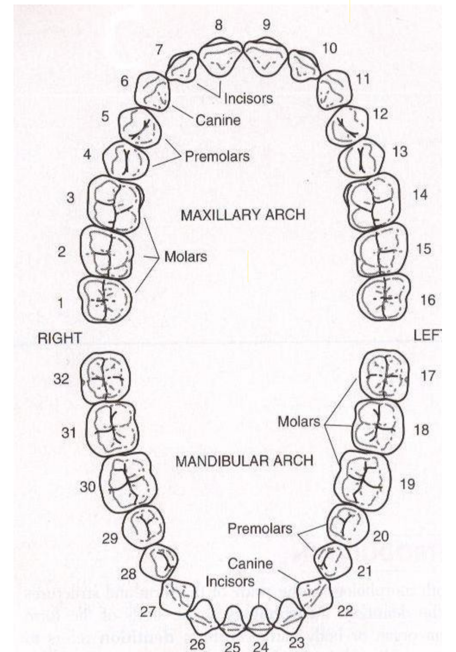
INSTRUCTIONS: This is an internal form only. Form to be completed by APA Staff to start referral process and determine dental emergency. **If patient answers yes to one or more of the questions in bold, it is considered an emergency and they will be sent to a dental emergency service provider after enrollment.**

Patient Name:____ DOB: __________
Address:____
Home: ____________________ Cell: ____________________ Work: ____________________

Email:____

□ Is patient in the office OR □ Calling
□ Explain APA program, financial requirements, dental program-phases w/ different dentists, emergency & preventative services
□ Explain volunteer component (Value $100 hr) □ Ask Volunteer Questionnaire (after other questions)
□ Explain must have a Dental Home (ANHC, MSHS, Etc.) Initial Exam & X-rays $25; will be responsible for payment
□ Is patient-- a patient of record at ANHC/MSHS Yes or No Last time seen at the clinic ______________
If NO, patient needs to complete all ANHC Dental Forms – no exception
If YES, patient to complete only- ANHC Dental Health History & ANHC Dental Clinic Agreement
□ Explain that in order to determine appropriate services need to ask a few questions. In patient's words describe pain: ____

	QUESTIONS TO BE ASKED	COMMENTS
Yes or No	**Do you have facial swelling or swelling around the tooth?**	Tooth#_____or location -Left or Right side -Upper or Lower jaw -Front or Back of mouth
Yes or No	**Do you have a problem swallowing or breathing?** (Swelling under the tongue or back of throat)	Send immediately to Emergency Dept.
Yes or No	**Do you have a cracked or fractured tooth?** Chipped, rough, broken or teeth with holes in them is not an emergency without the above symptoms.	
Yes or No	Is it affecting your sleep at night?	
Yes or No	Do you have a fever from this?	
Yes or No	Is it sensitive to heat, making it throb for a long time? (Cold sensitivity is not an emergency)	
Yes or No	Is it extremely sensitive to pressure or tapping on the tooth gently?	
Yes or No	Are you in constant pain? (If it is very intermittent or been off and on for a long time than not as urgent)	
Comments		



OUTCOME	
_____Urgency (1 -5)	Patient needs Emergency Service Provider – Urgency 1
Discuss with Pt	If Emergency Services are not required, let patient know once enrolled in the program, an appointment will be scheduled with ANHC Dental Clinic (or Dental Home) for an initial exam and x-rays. Patient will be responsible for $25 payment.
Intake Comments	
Intake completed	By______________________Date___________Dated Submitted to DHC __________