Name:

DOB:

Today's Date:

Salud Family Health Centers

CONSENT TO PERFORM INTERIM THERAPEUTIC RESTORATION (ITR)

Purpose: The purpose of this form is to obtain your consent to have procedures performed recommended for your child/ward for the following tooth/teeth:

Tooth Number(s):_____

Description of ITR Procedure:

1. The specific procedure that is being recommended is an "interim therapeutic restoration" (ITR). An ITR is a temporary filling that will stabilize the tooth/teeth until further evaluation or treatment by a dentist.
2. An ITR may prevent further decay or slow down tooth decay
    a. Loose food, debris or soft decay will be removed with a dental hand instrument.
    b. Some decay may be left in the tooth.
    c. A filling will be placed in the tooth/teeth to fill the hole until further evaluation or treatment by a dentist.
    d. Covering any decay left in the tooth may slow down the progression of decay and reduce the chance of having a toothache or infection.
    e. This procedure is generally comfortable and pain free.
    f. No local anesthetic is necessary; however, there may be some minor discomfort during the procedure.
    g. There is a small possibility of feeling pain in the tooth after the procedure.
    h. The patient may have an uncomfortable bite after the procedure, or the filling may not last.
    i. If the patient experiences problems with the filling, additional dental work may be needed.
3. If there is any pain following the procedure, please call the Salud clinic at (303) MYSALUD (303-697-2583).
4. The services listed above are not a substitute for a complete dental examination, diagnosis, and treatment by a dentist. Either party (patient or provider) can choose not to have the procedure performed. If the patient/guardian refuses treatment, it will not affect the right to future care or treatment.
5. There is no warranty or guarantee regarding the treatment or procedure that the patient may receive.
6. The patient/parent/guardian's identity will not be disclosed without separate consent, except as specifically described in this form or allowed or required by law. **I have been given full opportunity to ask questions about the procedure that will be performed to my child and any risk involved. I Voluntarily consent to authorize this procedure that was recommended to be performed on my child. I certify that I have read this form and that I understand its contents.**

Check appropriate " ◯ " to give your consent or refusal of treatment:

◯ I have read this form and I **CONSENT** to have the procedure described in this form performed on my child/ward.

◯ I have read this form and I **REFUSE** to have the procedure described in this form performed on my child/ward.

Parent/Legal Guardian (PRINT): _____

Patient/Parent/Legal Guardian Signature:_____ Date:_____

Signature of Witness: _____ Date:_____

Interim Therapeutic Restoration (ITR)

Patient Name_____DOB:_____

Registered Dental Hygienists' Name_____Dentist's Name_____

Tooth Numbers_____

I understand the following:

1. The procedure that is being recommended for my child is an Interim Therapeutic Restoration (ITR). An ITR is a temporary filling that will stabilize my child's tooth or teeth until I can take them to have further evaluation or treatment by a dentist.

   A. An ITR may prevent more decay or slow down tooth decay.

   B. Loose food, debris or soft decay will be removed with a hand instrument. Some decay may be left in the tooth.

   C. A filling will be placed in my tooth or teeth to fill the hole in the tooth until I am able to have further eval uation or treatment by a dentist.

   D. Covering decay left in the tooth will slow down the progression of decay and reduce the change of having a toothache or infection

   E. This procedure is generally comfortable and pain free.

   F. No anesthetic is necessary but there may be a chance of minor discomfort during the procedure

   G. There is a small possibility of feeling pain in my tooth after the procedure.

   I. Your child may have an uncomfortable bite that can be adjusted or the filling may not last which could be as simple as replacing the ITR

   H. If I experience problems with the filling or tooth, I may need additional dental work

2. No warranty or guarantee has been made to me regarding any treatment or procedure that I receive. If a problem occurs during or after the procedure, I understand that I can notify my dental home, Summit Community Care Clinic (970) 668-4055 or Lake County Dental (719) 427-0436 for additional treatment.

I have been given the opportunity to ask questions about the procedure that will be performed and any risks involved. I voluntarily consent to authorize this procedure to be performed for my child. I certify that I have read this form and understand it's contents.

School_____

Name of Patient_____ Date_____

Name of Parent/Legal Guardian_____

REFUSAL: I refuse to have the procedure described in this form performed on my child, or would like more information before I consent:

Parent Signature_____ Date_____

Phone number_____

Restauración Terapéutica Provisional

Nombre del paciente:_____Fecha de Nacimiento:_____

Nombre del Higienista Dental registrado:_____Nombre del dentista:_____

Número del diente/s:_____

Se me ha explicado lo siguiente:

El procedimiento que se recomienda para mi hijo es una Restauración Terapéutica Provicional (ITR por sus siglas en Inglés). Un ITR es un relleno temporal que estabilizará el diente o los dientes de mi hijo hasta que lo lleve a una evaluación o tratamiento adicional por un dentista.

- **-Un ITR puede prevenir más caries o frenar la caries dental.**
- **-Comida suelta, desechos, o caries suaves se eliminarán con un instrumento de mano. Es posible que quede algo de caries en el diente.**
- **-Se colocará un relleno en mi diente o dientes para llenar el orificio del diente hasta que pueda obtener una evaluación o tratamiento adicional por parte de un dentista.**
- **-Cubrir las caries que quedan en el diente frenará la progresión de las caries y reducirá la posibilidad de tener un dolor de muelas o infección.**
- **-Este procedimiento no es generalmente molestoso y no es doloroso.**
- **-No es necesario utilizar anestesia, pero puede haber una posibilidad de molestias menores durante el procedimiento.**
- **-Hay una pequeña posibilidad que sienta dolor en el diente después del procedimiento.**
- **-Su hijo podria tener una mordida incómoda que se puede ajustar, o el relleno puede no durar, si es así simplemente se podria reemplazar el ITR.**
- **-Si tengo problemas con el relleno o el diente, es posible que necesite trabajo dental adicional.**

No hay garantía alguna con respecto a ningún tratamiento o procedimiento que reciba. Si ocurre algún problema durante o después del procedimiento, entiendo que puedo notifiar a mi dentista en la Clínica Comunitaria del Condado de Summit al (970) 668-4055 o a Lake County Dental (719)427-0436 para tener tratamiento adicional.

Se me ha brindado la oportunidad de hacer preguntas sobre el procedimiento que se realizará y sobre cualquier persona involucrada. Autorizo voluntariamente a que se haga este procedimiento a mi hijo. Certifico que he leído este formulario y entiendo su contenido.

Escuela:_____

Nombre del paciente:_____ Fecha:_____

Nombre del Padre o Guardian Legal:_____

Negación: Me niego a dar consentimiento para que se realice el procedimento descrito en este formulario a mi hijo, o me gustaría obtener mas información antes de dar mi consentimiento.

Firma del Padre:_____Fecha:_____

Teléfono:_____

SKIPPY+ Filling Consent Form

At the last Skippy visit, your child was identified as needing routine restorative care (i.e. fillings). If you would like this treatment to be provided onsite at your child's school please complete and return this form to TCHNetwork by email, fax or drop off at our office so we can schedule an appointment. If you have questions please call 970-708-7096 or email info@tchnetwork.org.

Medical/Dental History:

Patient Name:		Parent/Guardian Name:	
Patient Sex:		Patient Date of Birth:	
Address:		Phone:	
		Email:	

1. Please indicate yes in the appropriate column

Yes	No	Type	Yes	No	Type	Yes	No	Type
		Allergies			Heart Murmur			Psychiatric Treatment
		Anemia			Heart Surgery			Radiation Treatment
		Arthritis			Hepatitis A/B/C			Seizures
		Asthma			High Blood Pressure			Sexually Transmissible Infection
		Bisphosphonates			HIV/AIDS			Steroid Therapy
		Bleeding/Bruising			Implants			Stroke
		Blood Transfusion			Jaundice/Liver Disease			Surgery
		Cancer			Kidney Disease			Thyroid Disease
		Chemotherapy			Low Blood Pressure			Tuberculosis
		Chickenpox			Measles/Mumps			Tumor
		Convulsions			Paralysis			Ulcers
		Diabetes			Psychiatric Treatment			Vision Changes
		Emphysema			Implants			Tobacco Use?
		Epilepsy			Jaundice/Liver Disease			Drug Use?
		Fainting			Kidney Disease			Latex Allergy?
		Frequent Headaches			Low Blood Pressure			Vinyl Allergy?
		Heart Disease/Attack			Measles/Mumps			Pregnant?

2. Has Your child ever experienced an unusual or allergic reaction to the following:

Yes	No	Type	Yes	No	Type
		Aspirin			Local Anesthetic
		Barbiturates			Narcotics
		Iodine			Penicillin

If he/she/they have had a reaction what typically happens?

_____

3. Please list any medications your child is taking:

_____

Informed consent: I hereby give my permission to the Dental Professionals ("Staff") of Tri-County Health Network's, Skippy Dental Program to place composite fillings on _____ (child's name), for whom I am parent of legal guardian.

I recognize that Tri-County Health Network prefers that I be present at the clinic, during the treatment of _____ (child name) for whom I am responsible. I realize my presence on site is preferred and not mandatory.

I understand that this dental treatment is not guaranteed. Treatment results are based on the condition and environment of the mouth and procedures may change once the dental staff visually examines the child the day of treatment.

I understand that it is my responsibility to notify TCHNetwork at 970-708-7096 should any undue or unexpected problems occur or if _____ (child name) experiences any problems relating to the treatment rendered or the services performed. I have been given the opportunity to ask any questions regarding the nature and purpose of composite fillings and have received answers to my satisfaction.

I voluntarily accept any and all possible risks, including the risk of substantial harm, if any, that may be associated with any phase of this treatment in hopes of obtaining the desired outcome. By signing this document, I authorize Dr. Christy Kopasz, DDS to render any services deemed necessary or advisable in the treatment of my dental condition, including the prescribing and administration of any medically necessary anesthetic agents and/or medications.

Parent/Guardian Signature_____

Parent/Guardian Printed Name_____

Relationship to Child_____

Contact number in case of emergency_____

Date_____

Cost:

- Skippy+ is offered at no out-of-pocket costs to all families.
- However, if you have Medicaid, CHP+, or private insurance, we will bill for services just like any other dentist.

Risk:

- The materials used and dental care provided in the Skippy+ program are the same as those in a dental office.
- Dental care may have risks that are rare and minimal.
- Dental staff provide the care using standard safety and sanitization procedures that include wearing latex free gloves, facemasks and eye shields.
- Injections and medications may be used in accordance to what you note on your child's health history and allowable medications list to keep your child comfortable.
- Minor pain may be associated with providing standard fillings may occur and should ease after the treatment is provided

Privacy Policy:

- Information collected in this program will be kept private, unless required by law or to bill your insurance, and will be shared only within the Skippy+ program.
- If your child does not have health insurance a TCHNetwork Navigator will contact you to offer help in getting coverage.

Rights:

- Ask questions and have them answered to your satisfaction before and after signing the consent form.
- If you would like further information or have questions contact TCHNetwork at 970-708-7096.

Following any filling there may be:

1. Sensitivity of teeth. Often after preparation of teeth for the placement of any restoration, the prepared teeth may exhibit sensitivity. The sensitivity can be mild or severe. The sensitivity can last only for a short period of time or last for much longer periods of time. If such sensitivity is persistent or lasts for an extended period of time, I will notify the dentist because this can be a sign of more serious problems.
2. Risk of fracture. Inherent in the placement or replacement of any restoration, is the possibility of the creation of small fracture lines in the tooth structure. Sometimes these fractures are not apparent at the time of removal of the tooth structure and/or the previous fillings and placement or replacement, but they can appear at a later time.
3. Necessity for root canal therapy when fillings are placed or replaced, the preparation of the teeth often requires the removal of tooth structures adequate to ensure that the diseased or otherwise compromised tooth structure provides sound tooth structure for placement of the restoration. At times, this may lead to exposure or trauma to underlying pulp tissue. Should the pulp not heal, which often is exhibited by extreme sensitivity or possible abscess, root canal treatment or extraction may be required.
4. Injury to the nerves. There is a possibility of injury to the nerves of the lips, jaws, teeth, tongue or other oral or facial tissues from any dental treatment, particularly those involving the administration of local anesthetics. The resulting numbness that can occur is usually temporary but, in rare instances, it could be permanent.
5. Aesthetics or appearance. When a composite filling is placed, effort will be made to closely approximate the appearance of natural tooth color. However, because many factors affect the shades of teeth, it may not be possible to exactly match the tooth coloration. Also, the shade of the composite fillings can change over time because of a variety of factors including mouth fluids, foods, smoking, etc. The dentist has no control over these factors.
6. Breakage, dislodgement or bond failure. Because of extreme masticatory (chewing) pressures or other traumatic forces, it is possible for composite resin fillings or aesthetic restorations bonded with composite resins to be dislodged or fractured. The resin-enamel bond can fail, resulting in leakage and recurrent decay. The dentist has no control over these factors.