Greenwoods™ Dental & Surgical Centres

Head Office: 693 McPhillips Street, Winnipeg, Manitoba R2X 2H6 (204) 774-7774 Fax: (204) 633-1143
246 Portage Avenue, Winnipeg, Manitoba R3C 0B1 (204) 779-7779 Fax: (204) 594-5768

Patient Contact Information

PLEASE COMPLETE THE FOLLOWING INFORMATION ACCURATELY INORDER TO BOOK YOUR APPOINTMENTS FASTER

Patient First Name: _____ **Patient Last Name:** _____

Patient Date of Birth (MM/DD/YYYY): _____

Address: _____

_____

Cell Phone: _____ **Home number:** _____

Alternate Cell Phone: _____ **Emergency Number:** _____

Email Address: _____

Alternate Email: _____

Preferred Mode of Contact: _____

Relationship to Patient: _____

Parent/ Guardian Name:

Health card Information:

- MB- PHIN (9-Digits)
- MB- MHSC (6-Digits)
- Other Province (including letters)

Patient's Facebook Profile: _____

You can find us at *https://www.facebook.com/sedationgwdc* Facebook Page

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Important things to Note

Location of Surgery	**246 Portage Avenue, Winnipeg, MB R3C 0B1**		
Contact Number	**Office:** 204-779-7779	**Direct:** 431-688-3707	**Fax:** 204-594-5768
Email Address	sedation@greenwoodsdental.com		

- We request you to arrive at least **30 minutes prior** your scheduled appointment
- Please note that arrival time and surgery time are subject to change if the facility makes changes to the slate.
- Unless arrangements have been made by your insurance(s), all overdue balancesare required one week prior to surgery.
- Please plan to have an escort before and after your appointment once a discharge time has been arranged.
- We also provide **city wide shuttle service** for our surgery patients.
- Payment options: In Office
  - Via DEBIT or Cash or CREDIT
  - 3% sur charge is applied to all credit card transactions
  - No PERSONAL CHEQUES are acceptable
- **A $500 RETAINER FEE** will be applied to your account for cancelling the surgical appointment without sufficient notice or missed appointment.
- If any fax needs to be sent to the transportation office for confirming the appointment, please advise our surgical consultant while booking the appointment.
- NOTE: if your escort doesn't accompany you or leave mid-way, **PATIENT HAS TO PAY $1000 IMMEDIATELY** to provide a **HEALTH CARE AID** after recovery.

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CONSENT TO PROCEDURE / TREATMENT / INVESTIGATION

_____ hereby authorize and request Dr. _____

Along with any assistant necessary, to perform upon me the following operation(s): _____

I understand that the nature and purpose of the above-mentioned procedure(s) is/are to: TO RELIEVE DISCOMFORT / PAIN

I also authorize Dr._____to do any therapeutic procedure or investigation that in their judgement may be advisable for my well-being.

I acknowledge that I have been advised that I will be charged a specialist fee(higher) whether a specialist or a general dentist (proficient in doing the procedure) operates as it depends upon the availability of what provider will be available that day.

The nature of the planned operation has been thoroughly explained to me and I have decided to proceed with this form of therapy over other alternate methods. I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made about the results of the operation or procedure planned. Furthermore, the risks and complications inherent in the operation have been explained to me and I accept these.

I further give permission to have such anesthetics administered to as Dr. _____ or the anesthetist deem necessary or advisable.

Pictures may be taken of the treatment site for record purposes, I understand that these photographs / videos will be the property of the attending physician. I do not agree to allow these pictures to be used for publication or teaching purposes. If I agree, I understand that my name and identity will be kept confidential and protected.

I agree to keep the office of Dr. _____ informed of my post-operative progress and I agree to cooperate with instructions given for my post-operative care.

In the event that a health care provider experiences a significant exposure to my body fluids, I consent to a sample of my blood being drawn and tested for transmissible infections (Hepatitis B, Hepatitis C, Human Immunodeficiency Virus), with the understanding that the results will be made known both to myself and to the exposed individual.

I have read the above form, and understanding its contents, I consent to this surgical procedure.

Signature of Patient or Legal Guardian _____

Name (Please Print) _____

Relationship (if legal guardian) _____

Witness _____ Date _____

I hereby acknowledge receiving a copy of the post-operative instructions which have been reviewed with me. I understand the advice and restrictions given and agree to abide by them. I will notify my doctor immediately if any unusual bleeding, respiratory problems, or acute pain occurs after my discharge from Greenwoods Dental Centre.

_____ _____
Signature of responsible party Date

_____
Witness

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PEDIATRIC GENERAL ANESTHESIA PRE-OPERATIVE INSTRUCTION

It is important for your child's safety that you follow these instructions carefully
Surgery may be cancelled if these instructions are not followed

Arriving at the appointment	We request you to **arrive at least 30 minutes prior** to your scheduled appointment time. A parent or guardian should accompany the child and must remain in the clinic until the treatment is complete.
Medications	Some medicines should be taken, and others should not. It is important to discuss this with your dentist during the consultation appointment prior to surgery. Patients should take their usual medications with a sip of water on the morning of their surgery.
Food and beverage	• It is extremely important that your child has an empty stomach when given an anesthetic. It will reduce the danger of vomiting and inhaling stomach contents into lungs while your child is asleep. • You must follow these instructions, or the procedure will be cancelled to ensure safety. We request no solid foods or unclear fluids (orange juice, milk, etc.) are ingested after midnight the night prior to the appointment. • This fasting is for your child's safety. A staff member will be contacting you no longer than **48 hours prior to the appointment** to go over these instructions as well as to confirm the appointment. • If we cannot confirm the appointment prior, we will cancel the appointment and need to reschedule for a later date.
Personal	• We recommend your child come in comfortable, loose fitter clothing pajamas, track/sweatpants, and a t-shirt). If you are bringing a young child, please do not dress them in on piece clothing. • We also recommend older clothing, as they may get stained or dirty during the procedure and recovery with blood or fluids. We often recommend a second set of clothing because it is possible, they might have an accident. • If your child wears diapers or pull-ups make sure they are fresh and bring a backup pair.
Change in health status	If there are any changes in the child's health, such as a chest cold or fever the day of the treatment, please contact our office immediately.
Activities	Do not plan activities for the child after the treatment. Your child will likely want to rest upon returning home. Do not send your child to school or plan for activities. Please monitor your child throughout the day following the surgery.

It is important that you understand the circumstances surrounding this treatment.
If you have any questions or concerns, please call our office at 204-779-7779

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PEDIATRIC GENERAL ANESTHESIA POST-OPERATIVE INSTRUCTION

Discharge

- We prefer that two adult accompany the child home in case the child needs assistance during the transport. Ensure that a responsible adult accompanying the child can drive or hire a taxicab.
- Public transportation is not acceptable. We also recommend bringing a plastic bag for the ride home in case of any nausea or vomiting following the surgery.

Food & Beverage

- To assist your child in a speedy recovery, it is important for your child to be well-hydrated after treatment. The first drink should be plain water then clear sweet drinks can be given. Things like clear juices, Gatorade, etc.
- Warm soft food may be taken when desired and in small portions such as Jell-o, pudding, soup, mashed potatoes, or ice cream. Do not encourage eating too soon because your child's stomach may be upset.
- If your child sleeps for a few hours, wake them up to give liquids. Nausea and vomiting are not uncommon after surgery. Gravel suppositories work very well for postoperative vomiting, if vomiting persists, contact the dentist or anesthesiologist.

Mouth numbness/ Persistent Cough

Your child's cheeks, lips and tongue may be numb after treatment. Please watch your child carefully for several hours to make sure they don't bite the cheeks, lips, or tongue. The anesthetic gas used is very dry and sometimes irritating. This may cause hoarseness or a croupy cough. Either of these conditions should pass within the first day.

Pain Management

Children's Acetaminophen (e.g., Tylenol) or Ibuprofen (e.g., Advil or Motrin) every 6-8 hours (if not allergic) will help alleviate discomfort and sore gums. Occasional postoperative fever may be managed with Acetaminophen.

Post-Dental Care

- If your child received any stainless-steel crowns, the gums will be especially sore, because they fir below the gums. These crowns will fall out with the baby tooth when the permanent/adult tooth comes in.
- we recommend avoiding sticky foods until the crown has come out. If your child has had crowns or space maintainers placed, please do not allow toffee, gum, liquorish, or ice chewing to prevent displacing or distorting them. If your child received a permanent stainless-steel crown, please discuss care options with the dentist.
- If your child had teeth removed, it is important to avoid spitting or using a straw for at least 24 hours. Any bleeding can be controlled by biting (not chewing) firmly on gauze pads placed overt the surgery site for at least twenty minutes. Your doctor may recommend an appointment for a postoperative visit within two to four weeks.

Contact Us

If your child experiences **elevated fever, sever bleeding of gums, severe pain, severe vomiting, or severe dizziness** for more than 24 hours following their appointment, please call the dentist **at (204) 779-7779.** If your child has any of these symptoms during the evening or when the office is closed, please go to your nearest emergency room.

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PEDIATRIC PRE-OPERATIVE ASSESSMENT

Patient Name _____ **Date of Birth** _____

Parent / Guardian Name _____ **Parent / Guardian Signature** _____

Has your child been seen or treated in a hospital? Yes ☐ No ☐

If yes, please describe _____

Any complications? Yes ☐ No ☐

If yes, please describe _____

Has your child ever had an anesthetic? Yes ☐ No ☐

Did your child have any problems with an anesthetic? Yes ☐ No ☐

If yes, please describe

Has someone in your family had a problem with an anesthetic? Yes ☐ No ☐

If yes, please describe _____

Does your child have any allergies? Yes ☐ No ☐

If yes, please describe _____

Was an allergy due to:

a) medicine? Yes No ☐ If yes, please describe

b) food? Yes No ☐ If yes, please describe

b) other? Yes No ☐ If yes, please describe _____

If your child has an allergy, do they have:

a) rash or hives? Yes ☐ No ☐

b) trouble breathing? Yes ☐ No ☐

c) high fever? Yes ☐ No ☐

Has your child had a cold or cough in the past week? Yes ☐ No ☐ If yes, please describe _____

Has your child been exposed to any infectious diseases in the past month? (e.g., chicken pox, measles, etc.) Yes ☐ No ☐

If yes, please list _____

Does your child have:

a) breathing problems? Yes No ☐ If yes, please describe _____

b) heart problems? Yes No ☐ If yes, please describe _____

c) seizure disorder? Yes No ☐ If yes, please describe _____

d) developmental delay? Yes No ☐ If yes, please describe _____

e) diabetes? Yes No ☐ If yes, please describe _____

f) other? Yes No ☐ If yes, please describe _____

Is your child receiving any medication now? Yes ☐ No ☐ If yes, please list _____

Does your child or anyone in the family have a bleeding problem? Yes ☐ No ☐

If yes, please list _____

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PEDIATRIC PRE-OPERATIVE ASSESSMENT

This form is to be completed by a Physician. **Fax (204) 594-5768**

Name **Gender** **Date**

Date of Birth **Email**

Phone (Home) **Phone (Cell)** **Phone (Other)**

Street Address **City** **Province** **Postal Code**

P.H.I.N. **M.H.S.C.**

PATIENT DEMOGRAPHICS

Date of Birth **Ex-Prem** Yes, No ☐ **Gestational Age at Birth** Weeks **Hospital**

Summary of Past and Current Medical / Surgery Problems (severity and treatment)

Precaution Alert(s) Methicillin Resistant Staphylococcus Aureus (MRSA +) ☐ Other ☐

Review of Systems

Other (including Family History of Anesthetic Problems)

Medications: Current:

Other:

Allergies: *eg. Latex, Drugs, Food*

Type	**Reaction**

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PEDIATRIC PREOPERATIVE ASSESSMENT

This form is to be completed by a Physician.

Physical Exam

Weight_____Height_____Temp_____HR_____BP_____SpO2_____RR _____

	N	AbN	Explain if Abnormal
Airway / Neck			
CVS			
Respiratory			
Abdomen			
Neuro			
Spine			
Musculoskeletal			
Skin			

Guidelines for Preoperative Testing in Children

A. Hemoglobin

1. Infants < 1 year
2. Patients at risk for hemoglobinopathy
   (i.e. affro caribbeans, hemophiliacs, positive family history)
3. Patients with history of chronic disease
   (e.g. congenital heart, rheumatoid arthritis, cystic fibrosia, chronic renal failure, mallgnancy, chemotherapy)
4. Surgery associated with potential significant blood loss
   - tonsillectomy and adenoidectomy
   - cleft palate
   - craniofacial repair
   - burn grafting
   - major orthopedic procedures: scoliosis repair, osteotomy
   - liver biopsy
   - cardiac procedures
5. History and physical exam suggestive of anemia
   - chronic blood loss
   - dietary insufficiency (e.g. significant dental)
   - pregnancy
   - fatigue, pallor and tachycardia

A hemoglobin done within 3 months of the time of surgery is adequate, provided there has been no intercurrent change in medical status.

B. Sickle Cell Prep

All patients of Afro-Caribbean descent.

C. Other tests

The need for pre-operative urinalysis, electrolyte determinations and chest x-rays is guided by the history and physical exam.

Current / Lab Work / Consults / Investigations

IIb_____Sickle Cell _____

Assessment / Perioperative Recommendations

Date_____Physician_____Contact Phone _____

_____
Signature