Community Dental Partners Program

(Non-Cosmetic Restorative Dentistry, Ministry of Social Development and Poverty Reduction (MHSD), Healthy Kids Program Clients)

- Please read all instructions prior to submitting this form
- Referring dental office to complete Sections A-D (must be typed)
- Completed Triage Form to be accepted via **email only** to CommunityDentalProg@cw.bc.ca

TRIAGE FORM

A. CARE PROVIDER INFORMATION		
DATE OF SUBMISSION (DD-MMM-YYYY)	NAME OF DENTIST	
DENTIST'S PHONE NUMBER	DENTIST'S FAX NUMBER	DENTIST'S E-MAIL

B. PATIENT INFORMATION			
LEGAL SURNAME	LEGAL GIVEN NAME		
BIRTH DATE (DD-MMM-YYYY)	AGE	ASA (AMERICAN SOCIETY OF ANESTHESIOLOGY) STATUS ☐I ☐II	
PERSONAL HEALTH NUMBER		☐ PERSON WITH DISABILITY	WEIGHT (KG)
STREET ADDRESS			
CITY	HOME PHONE NUMBER	WORK PHONE NUMBER	
PARENT(S) AND/OR GUARDIAN(S)/FOSTER PARENT(S)			
MHSD ELIGIBILITY FOR DENTAL TREATMENT CONFIRMED BY DENTAL OFFICE PERSONNEL ☐ YES		DATE (DD-MMM-YYYY)	INITIALS

C. PROCEDURE INFORMATION	
ADMIT DIAGNOSIS	CO-EXISTING MEDICAL CONDITIONS
ESTIMATED DENTAL OPERATING TIME (MINUTES)	PRIMARY PROCEDURE
SECONDARY PROCEDURE	ADDITIONAL PROCEDURE
ADDITIONAL COMMENTS	

D. RESOURCE PLANNING	
Patient recommended for care at Private Facility • Local hospital resources prevent this patient from receiving required care in a timely manner, **AND** • This patient meets all clinical eligibility criteria for a Private Facility ☐ **YES to BOTH of the above** Preferred Facility:	Suggested Treatment Date (DD-MMM-YYYY)

E. TRIAGE ASSESSMENT (to be completed by PHSA Triage Administrators)				
MHSD Eligibility Confirmed	☐ YES	☐ NOT ELIGIBLE	DATE (DD-MMM-YYYY)	INITIALS
APPROVED for Private Facility	☐ YES	☐ NO	DATE REVIEWED (DD-MMM-YYYY)	INITIALS
If NO, reason for decision				

F. FACILITY BOOKING CONFIRMATION (to be completed by facility booking personnel)		
DATE REFERRAL RECEIVED (DD-MMM-YYYY)	DATE OF SURGERY (DD-MMM-YYYY)	INITIALS

Instructions for Completion of Triage Form

- The Triage Form is to be completed for all Ministry of Social Development and Poverty Reduction patients recommended to receive non-cosmetic restorative dentistry services under general anesthesia at a private facility.
- Blank triage forms may be accessed via https://cwdentistry.phsa.ca/forms/TriageFormInstructions.pdf. To ensure legibility, PHSA requires that all information by **TYPED** into the online Triage Form. PHSA will not accept hand-written Triage Forms.
- Please note Triage Forms are only authorized and valid for the month in which the treatment is scheduled*.
  *The only exception will be for the first week of each month which will be processed in the last week of each month.
  We can not approve triages for treatments that occur in the future months due to potential changes in patient's benefit eligibility.

Referring Dental Office to complete Sections A to D of the Triage Form:

Section A – Care Provider Information

- Please provide general contact information, including name, phone number and e-mail address where the approved triage form is to be sent.

Section B – Patient Information

- Please provide the patient's general demographic information, including legal name and PHN.
- Please be sure to include the patient's age, ASA status and weight (patient's age must coincide with their date of birth).
- **Please note that the Dental Office is required to obtain confirmation of Ministry and Health and Poverty Reduction (MHSD), Healthy Kids and Pacific Blue Cross dental coverage eligibility for the month when the treatment is scheduled.**

Section C – Procedure Information

- Please provide information regarding the patient's admit diagnosis, co-existing medical conditions and primary/secondary/additional procedures. **For ASA II patients, disability must be formally diagnosed.** Please include an estimate of the total dental operating time required.

Section D – Resource Planning

- Please confirm that BOTH of the following conditions apply:
  1) Local hospital resources prevent this patient from receiving required care in a timely manner AND
  2) This patient meets all clinical eligibility criteria for a Private Facility
- Please provide name of preferred facility and the suggested treatment date.

Completed form MUST BE EMAILED to CommunityDentalProg@cw.bc.ca, for review and approval by Triage Administrators or designate. Note: Faxed forms are no longer accepted.

- The Triage Form will be reviewed and a response sent to the referring dental office by email within **3 to 5 business days**.
- **For urgent cases** which require approval within less than 3 business days, referring dental office is asked to include URGENT in the email subject and mark as "high importance".

The referring dental office is responsible for booking the patient at the approved Facility in accordance with the Facility's specific booking protocol.

Please limit any bulk triage form submissions to treatments that are scheduled to take place within the same week. Any urgent cases must not be submitted as part of a bulk triage email.

January 2023