CONSUMER ADVISORY BOARD
WILLOWBROOK CLASS
1050 FOREST HILL ROAD
STATEN ISLAND, NY 10314
(718) 477-8800 FAX (646) 766-3488

Dental Consent Overview

[Attach all applicable consults.]

Class member name: _____ DOB: _____Age: ___

Home Address: _____

Primary Health Services Contact [RN or MD]: _____

Telephone: Day _____ Evening _____

Secondary Contact: _____
Telephone: Day _____ Evening _____

Is an Expedited Review Necessary? ___ Yes ___ No
If an expedited review (within 8 business days after CAB receipt) is requested, please explain the dental circumstances:

ALL QUESTIONS MUST BE ANSWERED TO PREVENT UNNECESSARY DELAYS.

Recommended Procedure [*Attach all applicable consults*]: Dental work under general anesthesia

Description of Dentist's recommendation:

Risks & Benefits:

Dental History [this information must be indicated below]:

Current # of teeth:_ _____

Oral hygiene: _____

Current diet

Will diet require reassessment? ___ Yes ___ No

If yes, explain:

Previous exams and level of cooperation:

Medical History:

Diagnosis:

Current Medications:

Allergies: ____ Yes ____ No If yes, list

Previous invasive procedures with date/results/complications [related or unrelated]:

Dentist: _____ Telephone: _____

Primary Physician: _____ Telephone: _____

Second opinion: ☐ Yes ☐ No
Date obtained: _____ [*Attach all applicable consults.*]
Dentist: _____ Telephone: _____

Is there an alternative procedure: ☐ Yes ☐ No

If yes, state the procedure, explain the risks/benefits and why this is not the preferred option:

Is there family/guardian: ☐ Yes ☐ No Is there a health care agent: ☐ Yes ☐ No

If yes to either of the above, explain:

Local CAB Representative: _____

Provide dates of all contacts with the local CAB Representative in regard to this proposed medical procedure:

Return address for signed consent(s):

Submitted by Name/Date/Phone: _____
Reviewed by Name/Date/Phone: _____

CAB Use Only:
Date _____
Initial _____

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