**SHS BOTSWANA PRE-AUTHORISATION REQUEST FORM**

**Specialised Dentistry, Periodontal Treatment, In – Hospital and Conscious Sedation**

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| **Please email to** dental@shsbotswana.co.bw |

Member to Complete:

|  |  |
| --- | --- |
|  Date |  |
|  Membership Number |  |
|  Main Member’s Name and Surname |  |
| Patient’s Name and Surname |  |
|  Dependant Code |  |
|  Date of Birth |  |
|  Option |  |
|  Main Members Telephone Number |  |
|  Main members Mobile Number |  |
|  Main members E-mail address |  |

Members Signature: ­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To be completed by Practice Accounts Department:

|  |  |
| --- | --- |
|  Practice Name |  |
|  Doctor’s Name and Surname |  |
|  Practice No |  |
|  Practice Tel No |  |
|  Practice Fax No |  |
|  Practice E-mail address |  |

Type of Procedure:

* Specialised Dentistry
* Periodontal Treatment
* Dentistry done under General Anaesthetic in Hospital
* Dentistry done under IV sedation in Rooms
* Dentistry done under IV sedation in Hospital

Hospital Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital Practice No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Admission date: \_\_\_\_\_\_\_\_\_

**Clinical Motivation for the Procedure**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Nature of Procedure and Brief Clinical History**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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PERIODONTAL CHARTING

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| **DIAGNOSIS** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **BLEEDING** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **MOBILITY** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **POCKET DEPTH** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **TOOTH NUMBER** | **8** | **7** | **6** | **5** | **4** | **3** | **2** | **1** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | 8 |
| **POCKET DEPTH** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **FURCATION** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **MOBILITY** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **BLEEDING** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| **DIAGNOSIS** |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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| **DIAGNOSIS INDEX** |

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| **CPITN** |  |  |  |
| **SCORE** |  |  |  |

**Treatment Plan and Cost Estimate:**

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| **PROCEDURE  CODE** | **DESCRIPTION** | **UNITS** | **DIAGNOSIS****CODE****(ICD 10)**  | **TOOTH NUMBER** | **AMOUNT** |
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| **LABORATORY  CODE** | **DESCRIPTION** | **UNITS** |  |  | **AMOUNT** |
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Dental Procedures already performed and outcome: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please Note:** Radiographs are requested for purpose of benefit allocation.

Date of Procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dr Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOCTOR OFFICIAL STAMP