Janeway
DENTAL CLINIC

Dear Parent,

As you know, children with Autism Spectrum Disorder (ASD) and related conditions often have a difficult time receiving dental care. We recognize that each child has unique strengths and challenges and must be treated as an individual. To more effectively care for our patients, we have adopted a specific care approach for children with ASD.

- New patients are asked to complete the Pre-Visit Questionnaire included in the following pages. Please complete the form to the best of your ability and return it to our clinic. Once received, our team will review the information and call to schedule your child's first visit.
- During the first visit you and your child will have the opportunity to see the clinic, meet the staff, and discuss treatment strategies with the dentist. The first visit is an opportunity for us to learn more about your child's unique strengths, determine any special accommodations required, and develop a unique plan for his/her care. We don't want you to feel pressure to have any treatment completed at this visit. Some children allow a dental exam on the first trip to our clinic, but for others it may take a few more visits.
- Subsequent visits to our clinic will focus on 1) completing dental care 2) obtaining a set of skills which will enable your child to maintain optimal oral health for a lifetime. These visits are typically scheduled for 30 minutes, but will vary depending on your child's needs.
- We have placed a Social Story on our website. Please make use of this resource before your visit if you think it would help your child: https://www.janewaydental.ca/social-story

We understand that this approach requires a considerable amount of your time, and we thank you for your participation. If this approach does not seem appropriate for your child, please call our office at: (709) 777-4353 to speak with our team. It is always possible to make alternate arrangements for care.

We look forward to meeting you soon,

Sincerely,

Janeway Dental Clinic

Janeway Dental Clinic 300 Prince Philip Drive, St. John's, NL A1B 3V6
Tel: (709) 777-4353 Fax: (709) 777-4171 Email: dentistry@easternhealth.ca
www.janewaydental.ca

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Pre-Visit Parent Questionnaire for Patients with ASD

Date _____

Child's First and Last Name _____ Age _____

Address _____ Phone # _____

Medical Diagnosis _____

Medications _____

Allergies _____

You may include a separate written list of medications and allergies if there are a large number of items

Who referred you to us? _____

Your Child's Primary Care Doctor _____

PLEASE CHECK OR CIRCLE All THE RESPONSES THAT ARE APPROPRIATE FOR YOUR CHILD

<u>Your child's educational support system</u>

☐ Has an educational assistant or behavioral therapist

☐ Has a personalized school program in place (IEP)

☐ Classroom type (Circle one) ☐ Integrated class ☐ Special Education

☐ Other _____

<u>How would you describe your child's ASD?</u>

☐ Mild ☐ Moderate ☐ Severe ☐ Don't Know

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How does your child communicate?

Language Understanding	☐ Limited	☐ Some	☐ Most
Speech	☐ Non-verbal	☐ Limited verbal	☐ Highly verbal
Reading	☐ Non-reader	☐ Some reading	☐ Fluent reader
Complies with simple instructions	☐ Rarely	☐ Sometimes	☐ Usually

What tools does your child use to communicate?

☐ Social Stories ☐ Visual Schedules ☐ iPad ☐ Pictures

Other _____

Which activities can your child do on their own?

☐ Toileting ☐ Tooth brushing ☐ Bathing ☐ Hair brushing ☐ Dressing

What are your child's strengths?

What are your child's interests?

Is your child sensitive to any of the following?

☐ Loud Noises ☐ Bright Lights ☐ Unfamiliar Smells ☐ Unfamiliar Tastes

Other _____

What are the best rewards for your child?

☐ iPad/tablet time ☐ Prize/trinket from dentist ☐ Special food/meal ☐ Special outing

Other_____

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What kind of treatment would you like our team to provide?

☐ Routine Exam Cleaning ☐ Filling/Crown ☐ Extractions ☐ A lot of work ☐ Orthodontics

What would be your preferred way to accomplish your child's care?

☐ Desensitization/Behavioral Approach

☐ Sedation/General Anesthesia

☐ Restraint/Protective stabilization

☐ Other, Describe:

How did your child's last dental visit go? What could have made it easier?

Is there anything else that you would like us to know about your child?

Thank you for completing this form. The information will be used to help your child with dental treatment.

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