Silver Diamine Fluoride Integration into Primary Care in Maine

A Case Study

August 2025

FROM THE FIRST TOOTH
HEALTHY SMILES FOR LIFE

ACKNOWLEDGEMENTS

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Children's Oral Health Network of Maine

MaineHealth

CXD Career Exploration & Development

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INTRODUCTION TO SILVER DIAMINE FLUORIDE

Dental caries is the most common chronic disease of childhood. Limited access to a dental home and dental insurance present barriers to a child obtaining regular preventive dental care. Due to the frequency of dental caries, more accessible solutions are needed in clinical settings. Silver Diamine Fluoride (SDF) is an alkaline fluoride liquid solution that is used to arrest carious lesions and prevent the spread of cariogenic bacteria.[1] SDF was FDA approved in 2014 for dental hypersensitivity and labeled as a breakthrough therapy for arresting caries in 2016.[2] Advantage Arrest™ Silver Diamine Fluoride is currently in Phase III trials to become the first drug approved for caries treatment.[3,4] SDF application is odorless, minimally invasive, and takes only a few minutes. SDF is carefully applied to the carious lesion and turns the area of decay black. The black staining serves as a visible indicator that the decay has been halted. Healthy enamel is not stained by SDF application.

Photo provided by Southern Maine Pediatric Dentistry

SDF has been used to treat dental caries for years in many countries including: Japan, China, Australia, Brazil and Canada. SDF continues to gain popularity in U.S. dentistry as dental providers move from traditional "drill and fill" approach towards newer minimally invasive care options. [2,5] SDF has long been used around the world, and its popularity in U.S. dentistry continues to grow as providers shift toward minimally invasive approaches. Building on this momentum, SDF is now entering the primary care setting, offering medical providers a practical tool to arrest dental decay while they work to connect children to a dental provider.

SILVER DIAMINE FLUORIDE IN PRIMARY CARE

For families, having SDF in the primary care setting increases access to dental treatment. Many families struggle to find regular dental care and are much more likely to see their child's primary care provider. If dental decay is left untreated, the cavity can lead to pain and infection. SDF's silver property acts as an antimicrobial which inhibits the growth of bacteria, while its fluoride component promotes remineralization of the tooth, preventing caries from progressing.[2] According to one study, the use of SDF treatment reduced the instance of dental emergencies by 80% when compared to a control group.[6] Contraindications to SDF include silver allergy or pulpitis*, in which

[1] Siefo, N., et al. The Use of Silver Diamine Fluoride (SDF) in Dental Practice. *British Dental Journal.* 2020 January 24;228: 75-81. https://doi.org/10.1038/s41415-020-1203-9
[2] American Dental Association. *Silver Diamine Fluoride.* September 2023. https://www.ada.org/resources/ada-library/oral-health-topics/silver-diamine-fluoride
[3] Elevate Oral care. *Advantage Arrest Silver Diamine Fluoride 38% - 8mL Bottle.* https://www.elevateoralcare.com/Advantage-Arrest-Silver-Diamine-Fluoride-38
[4] Fontana, M. (2019). *Phase III RCT of the Effectiveness of Silver Diamine Fluoride in Arresting Cavitated Caries Lesions.* University of Michigan at Ann Arbor. https://granttome.com/grant/NIH/U01-DE027372-01
[5] Farmer, J. W., et al. (2018). Effectiveness, safety, and acceptance of silver diamine fluoride therapy and its implications for dental hygiene practice: Position paper and statement from the Canadian Dental Hygienists Association. *Can J Dent Hyg* 2018;52(3): 192-207. https://files.cdha.ca/professional/SDF_Position_paper_cjdh_v52n3_FINAL.pdf
[6] Thomas, M. L., et al. (2020). Silver Diamine Fluoride Helps Prevent Emergency Visits in Children with Early Childhood Caries. *Pediatric Dentistry.* 2020 May 15;42(3): 217-220.

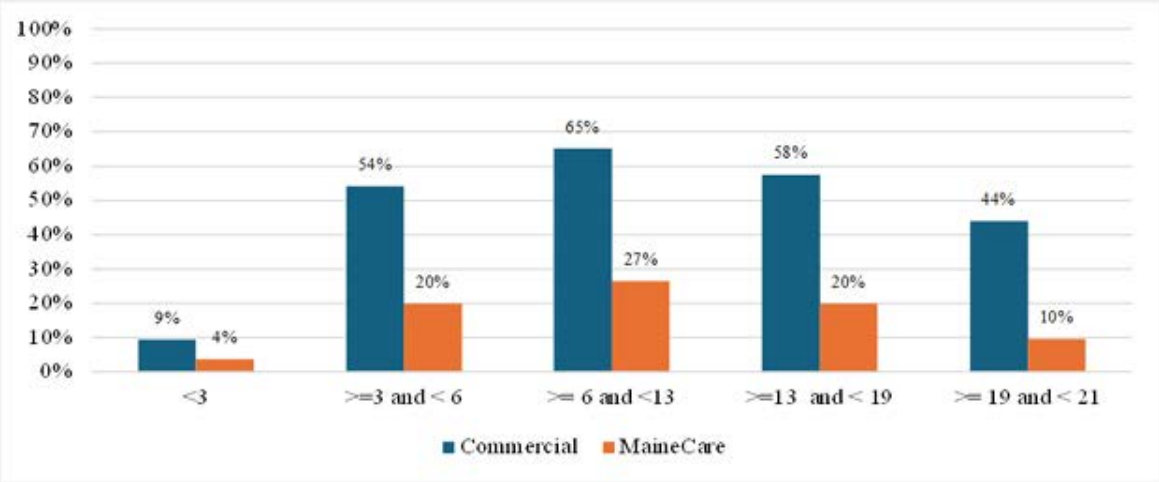
case an immediate referral to a dental provider is recommended.[7] The implementation of SDF in primary care has potential to treat and prevent dental caries and significantly improve oral health outcomes and access for children in Maine.

ACCESS TO ORAL HEALTH CARE IN MAINE

The dental home is a key indicator of optimal oral health care for children in Maine. The dental home ensures that oral care is delivered safely and continuously throughout life.[8] The gap in access to a regular dental provider remains a significant obstacle in obtaining routine preventive dental care for children in Maine. Although dental insurance coverage for children has been increasing in Maine, approximately 96,000 children in Maine had no dental insurance coverage or inconsistent coverage in 2022.[9]

As recommended by the American Academy of Pediatric Dentistry and American Academy of Pediatrics, a dental home should be established by 12 months of age.[8] Evidence shows that receiving early preventive care before 12 months reduces the cost of treatment and risk of future oral health disease.[10] In Maine, children ages 0-2 are some of the least likely to receive early preventive care with only 4% MaineCare enrolled and 9% of commercially insured children having a dental home. The age group with the highest percentage of children with a dental home are ages 6-13, but commercially insured children (65%) are more than twice as likely as children with MaineCare coverage (27%) to have received an annual checkup and cleaning. Young adults aged 19-21, particularly those with MaineCare coverage, also see lower rates having a dental home to about 10% shown in Figure 1.[11]

Figure 1. Percent of consistently insured children who had a dental home by age and payer (2022)



[7] Silver Diamine Fluoride (SDF) Indications and Contraindications. *American Academy of Pediatrics.* June 2024. https://www.aap.org/en/patient-care/silver-diamine-fluoride-application-in-the-pediatric-medical-setting/silver-diamine-fluoride-indications-and-contraindications/

[8] Definition of Dental Home. *American Academy of Pediatric Dentistry.* (2023). https://www.aapd.org/research/oral-health-policies--recommendations/Dental-Home/

[9] 2022 Dental Claims Data Update 2016-2022 Trends. Children's Oral Health Network of Maine. February 2024. https://www.mainecohn.org/assets/stock/2022-COHN-Data-Brief.pdf

[10] Savage, F. M., et al. (2024). Early Preventative Dental Visits: Effects on Subsequent Utilization and Costs. *Pediatrics.* 2004 October; 114(4): 418-423. https://doi.org/10.1542/peds.2003-0469-F

*Pulpitis: Pulpitis is an inflammation of the pulp, the soft inner tissue of the tooth.

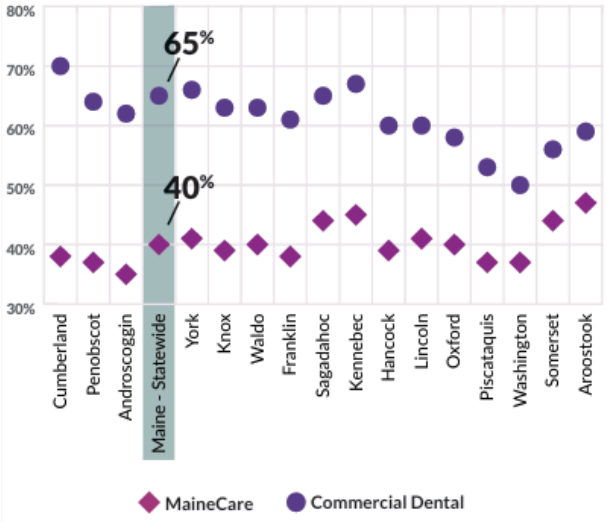
*Consistently insured is defined as being enrolled in a dental insurance plan for at least 11 months out of the measurement year.

[11] *Fox, K. S., Kumarage, A., McGuire, C., & Stultz, E. (2024). Assessing Maine children's access to a dental home: Dental insurance does not guarantee receipt of dental care. University of Southern Maine, Muskie School of Public Service Catherine E. Cutler Institute, Population Health & Health Policy*

Source: University of Southern Maine, Muskie School of Public Service (2024); Cited from MHDO APCD Claims and Eligibility 2018-2022 run date December 12, 2023.

Maine's geography has strong influences on preventive oral health in urbanized and rural areas. Studies show that children living in rural areas are less likely to receive preventive care, like fluoride treatments or sealants, than children in urban areas. [12] According to the Children's Oral Health Network 2022 Data Brief report Maine's more rural counties like Lincoln, Franklin, and Penobscot have some of the lowest rates of children receiving preventive oral care. As seen in Figure 2, Androscoggin county is reported to have the lowest percentage of children with Mainecare who receive preventive care, followed by Washington and Piscataquis.[9]

Figure 2. Disparities in preventive dental care by county for consistently insured children (2022)

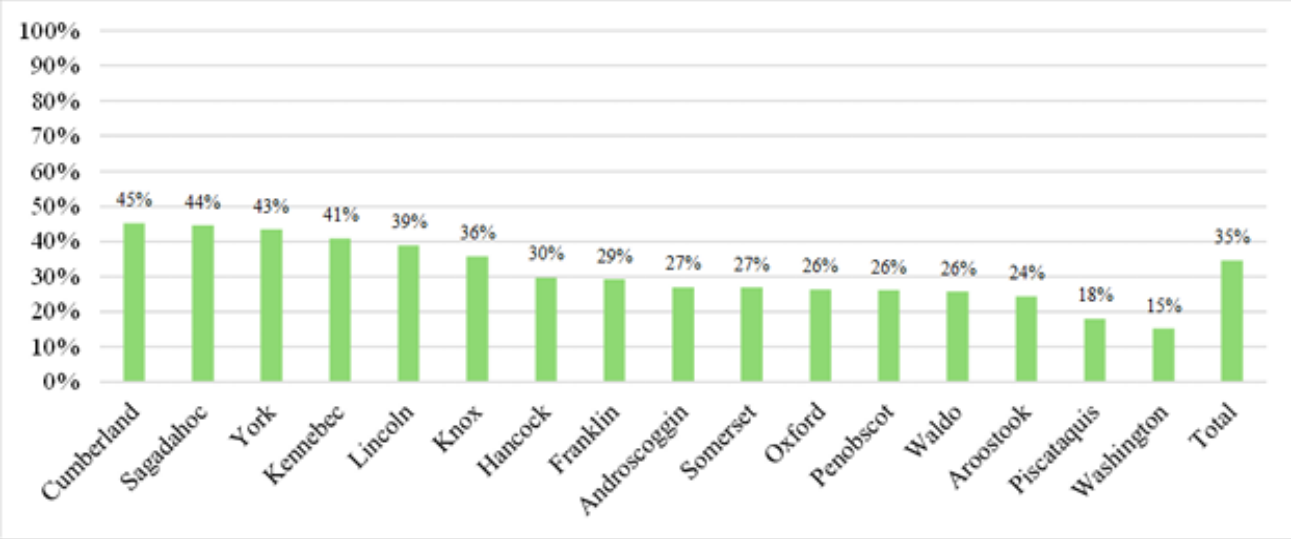


Source: 2022 dental claims data from the Maine Health Data Organization's All-Payer Claims Database

Note: graph formatting attributable to the American Dental Association Health Policy Institute's Dental care use among children (2016).

In 2022, it was reported that only 15% of children in Washington county had an active dental home while Cumberland, Kennebec, Sagadahoc, and York had more than 40% of children with an active dental home shown in Figure 3.[11]

Figure 3. Percentage of consistently insured children who had a dental home by county, sorted by total rate (2022)



Source: University of Southern Maine, Muskie School of Public Service (2024); Cited from MHDO APCD Claims and Eligibility 2018-2022 run date December 12, 2023.

[12] Crouch, E., Nelson, J., Merrell, M., Martin, A. (2021). The oral Health Status of America's Rural Children: An Opportunity for Policy Change. *Journal of Public Health Dentistry.* 2021 January, 27; 81(4):251-260. https://doi.org/10.1111/jphd.12444

With such low rates of Maine children receiving routine preventive oral care, integrating oral health into primary care is becoming more important. The World Health Organization set a global target of 80% of countries to have integrated oral health services into primary care by the year 2030.[13] Maine has been working towards increased oral health integration into primary care since 2015 through the From the First Tooth program (FTFT).

FTFT is a statewide children's oral health program that works to integrate evidence-based oral health services into the well child visit for children ages 6-months up to 21 years. Specifically, FTFT provides technical assistance to primary care practices to provide oral health evaluations, fluoride varnish application, parent and caregiver education, and referrals to a dental provider.[14] FTFT maintains a database of 242 primary care practices and tracks program participation. The program also tracks fluoride varnish application rates over time by analyzing claims data which is used to identify trends and needs for further assistance.[15]

FTFT is a key collaborator of the Children's Oral Health Network of Maine's Health Integration Action Team (HIAT) which is a collaboration of many partners including Maine Center for Disease Control and Prevention (CDC), Maine Chapter of the American Academy of Pediatrics, MaineHealth, MCD Global Health, Northern Light Health Care, and Maine Primary Care Association. The HIAT works to address access to oral health care through integration into primary care. Specifically, FTFT is working with the HIAT to develop tools, protocols and trainings to support the integration of SDF into primary care to treat childhood dental caries.

INSIGHTS FROM A SILVER DIAMINE FLUORIDE PILOT

In 2022, a group of MaineHealth pediatricians recognized the potential of using SDF treatment as a patient-centered tool to address dental caries during the well-child check. MaineHealth pediatricians partnered with the FTFT program to initiate SDF service integration into the MaineHealth system which resulted in the launch of an SDF integration pilot. This report provides a review of the following components that resulted from the pilot:

1. **SDF integration framework**: Details are provided on the steps used to integrate SDF into the MaineHealth system.
2. **SDF provider training and training case study:** An overview of the training structure is provided followed by an SDF training case study at a pediatric medical practice in Westbrook ME.
3. **SDF implementation case studies:** A residency program in Portland ME and a rural health center in Damariscotta ME were assessed for provider preparedness and workflow logistics. This report includes general observations from each practice.

[13] World Health Organization. *WHO Discussion Paper: Draft Global Health Action Plan (2023-2030).* August 2022. https://cdn.who.int/media/docs/default-source/ncds/mnd/eb152-draft-global-oral-health-action-plan.pdf?sfvrsn=ecce482e_4
[14] From The First Tooth. *Oral Health Resources by State: Maine.* https://www.fromthefirsttooth.org/by-state/maine/
[15] From The First Tooth. *Annual Update 2023.* https://www.fromthefirsttooth.org/wp-content/uploads/2024/04/annual-update-2023-4.1.24.pdf

SILVER DIAMINE FLUORIDE SYSTEM INTEGRATION

An integration framework was created to assist in adoption of SDF by the MaineHealth system. Tasks were delineated within each domain and implemented in a stepwise manner. An overview of each step is detailed below:

Leadership Approval

SDF integration into the MaineHealth system was led by a group of four physician champions and guided by the FTFT program. Various leaders within the pediatric health service line were consulted throughout the SDF integration process. Additionally, the SDF procedure was brought to two pediatric physician groups within the MaineHealth Medical Group for feedback and recommendations. Throughout this process strong physician leadership was key to moving integration forward.

Service Approval

MaineHealth requires a new service request form be submitted to the revenue integrity department at the initiation of a new service or treatment. The new service request form assessed current literature/recommendations, procedure type, and billing codes/reimbursement.

Electronic Medical Record Integration

The SDF procedure was integrated into the electronic health record system, Epic. After gaining committee approval, the physician champions in partnership with FTFT and an Epic application specialist, outlined the necessary components to be included in Epic. A procedure document was custom built to accommodate the SDF procedure.

Billing Code Integration

Reimbursement for SDF in Maine differs based on payor and practice type. For commercial payors the code CPT 0792T was integrated into the billing system. MaineCare, Maine's Medicaid program, requests that practices use the CDT code D1354 when billing for the SDF procedure which was also integrated into the MaineHealth billing system.

Consent Form and Patient Education

FTFT worked with MaineHealth's Center for Health Improvement Patient Education team to create a consent form and patient education material. The patient education provides information on the SDF procedure including staining and the risks and benefits. The patient education material was translated into five of the most frequently used languages within the MaineHealth system.

Workflow Optimization

Multiple factors were taken into consideration when determining the best workflow for the two participating practices. These factors included: practice type, staff availability, and flexibility of well-child check structure.

Provider Training

FTFT worked with the Health Integration Action Team to develop and implement SDF training for the MaineHealth system.

SILVER DIAMINE FLUORIDE TRAINING

Training Development

The SDF medical provider training was developed in collaboration with the Health Integration Action Team, FTFT and pediatric dentists. The training consists of two primary components: an online module by that national training organization, Smiles for Life Curriculum, and an in-person hands on training led by a registered dental hygienist. This dual structure ensured that participants developed both a foundational understanding of SDF and the practical skills necessary for its use in clinical settings. The training was designed to be accessible and adaptable, emphasizing the value of revisiting the online curriculum for reinforcement and encouraging questions during hands-on sessions to support provider confidence and consistency in application. Physicians were also encouraged to utilize relationships with local dental providers to strengthen referral processes and explore shadowing and consultation possibilities.

Image of the Smiles for Life Curriculum online training

Training Overview

- ***Smiles for Life Curriculum***

The SDF module within the Smiles for Life Curriculum offers an overview of silver diamine fluoride's mechanism of action, indications for use, contraindications, and step-by-step guidance on application techniques.

- ***In-person hands on training***

A registered dental hygienist leads the in-person hands on training. During the training the content introduced by the Smiles for Life Curriculum module is reinforced through hands-on practice, discussion, and workflow integration.

Participants practice SDF application using tooth models and supplies. A strong emphasis is reiterated from the Smiles for Life curriculum on the importance of communication strategies that help reduce caregiver anxiety—for example, using the phrase "this turns the cavity from brown to black" rather than "this turns the tooth black."

The in-person training also includes an overview of the consent form process and how to document the SDF procedure in the electronic health record.

Overall, the in-person session serves as an opportunity to solidify knowledge from the online training, build provider confidence, and address practical considerations in clinical workflow, patient communication, and documentation.

CASE STUDY: SDF TRAINING AT A PEDIATRIC PRACTICE

Methods

To understand how SDF training translated into clinical readiness, in-person observations were conducted during a training session at MaineHealth Pediatrics Westbrook. Observations focused on provider engagement with the material, informal feedback on implementation challenges, and specific questions that arose during the session.

Observations

Providers at MaineHealth Pediatrics Westbrook demonstrated strong engagement throughout the session, particularly during the hands-on portion of the training. Many participants referenced content from the Smiles for Life Curriculum module, and several commented on the convenience of having continued access to the online curriculum.

Practical application questions emerged frequently during the session, indicating active integration of the training into clinical reasoning. Topics raised included:

- *Application frequency*: Providers asked how often SDF should be reapplied, particularly for lesions that do not appear fully arrested after the first visit.
- Technique nuances: There was discussion about whether the microbrush should be held on the tooth surface for several seconds or simply dabbed, and how best to isolate the treated area.
- *Material handling:* Several participants asked whether a single ampule could be used across multiple lesions or quadrants, and whether the brush should be re-dipped between applications.
- *Use of tools:* Providers inquired about the appropriateness of dental explorers for caries identification or SDF application.
- Consent language: Providers reflected on the importance of clear, non-alarming phrasing when describing staining.
- *E-Consults:* Participants acknowledged the importance of having dental professionals available for consultation during early implementation.

The convenience of pre-packaged SDF kits was also discussed, with providers expressing appreciation for their simplicity.

Finally, documentation and billing were reviewed using Epic, led by a staff member who demonstrated how to record SDF procedures, apply correct procedural codes, and distinguish between standard fluoride varnish and SDF for billing purposes. Providers responded positively to this component, and several commented on how helpful it was to see a concrete workflow example.

Results

Overall, the training session at Westbrook Pediatrics provided an effective transition from theoretical knowledge to practical application. The interactive environment allowed providers to clarify procedural details, share insights, and discuss strategies for integrating SDF into their clinical routines with attention to both medical and interprofessional best practices.

SDF IN PRACTICE

To better understand the clinical integration and implementation of SDF in a pediatric healthcare setting, qualitative observational data were collected at two distinct primary care practices: a pediatric residency clinic and a rural health center. The purpose of this observation was to document information related to SDF clinical workflows, application logistics, patient consent, education practices, as well as to identify any barriers or facilitators for effective use. While SDF application was only observed at the residency clinic, the rural health center provided an opportunity to review provider workflow and decision making in determining whether SDF should be offered to a patient.

Methods

An original set of guiding questions was developed prior to clinic visits to standardize the observation process. These questions were designed to capture clinic-level information (e.g., arrival procedures, supply storage, education strategies, and follow-up scheduling) and provider-level experience (e.g., consent duration, number of teeth treated, referral patterns, and challenges encountered during treatment). The data collection form can be found in appendix A.

In each clinic, observations were conducted in person during times SDF would most likely be applied. Notes were taken in real-time, either during or immediately following each patient's encounter. The same guiding questions were used at the two sites, although not all questions were applicable at both locations. At both clinics, observations included multiple patients over the course of a clinic day. For each encounter, it was indicated whether it was a first time SDF application visit, the duration of the consent and treatment processes, the presence of an interpreter, and any logistical or behavioral challenges that arose. Observers also documented broader clinic processes, such as how patients were scheduled, whether "Spruce the Dental Health Moose" dental family kits with toothbrushes and toothpaste were distributed, and the clinic staff's perceptions of the SDF application.

These observational data were later reviewed to identify patterns in implementation practices, education delivery, and barriers to care across diverse clinical contexts.

SDF IMPLEMENTATION CASE STUDY 1: A RESIDENCY PROGRAM

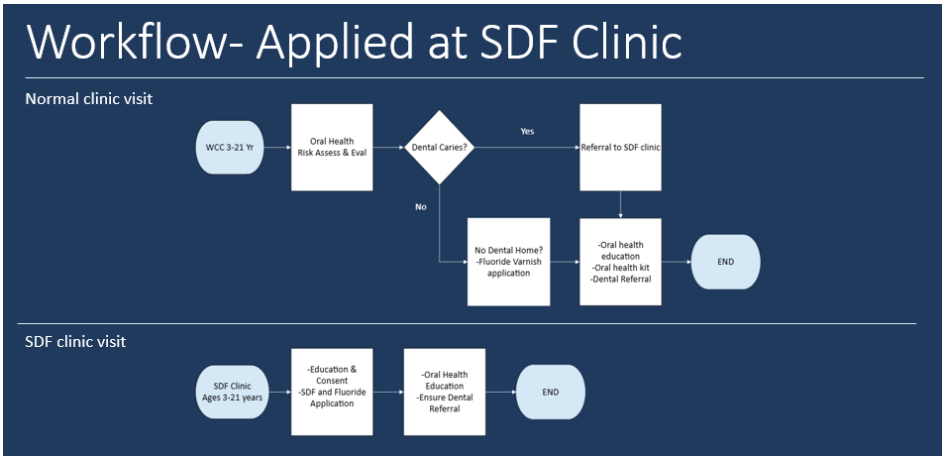
The MaineHealth Primary Care Pediatrics Portland is a residency practice in Portland Maine with a patient population of which more than 50% of patients are non-English speaking, and dental access is a challenge. The residency program determined that the best workflow for the practice was to identify dental caries during the well-child check and if needed refer patients to an SDF application clinic held monthly. Observations for this case study took place on two separate days in summer of 2025.

Setup

SDF kits were stored in a designated closet and were brought into the examination room. SDF application materials were placed beside the exam table, and the child was asked to lay on the exam table. Procedure documentation was completed either by the resident—who recorded notes as the provider spoke—or by the attending physician, depending on the context of the visit.

Workflow

- ***Identification and referrals:*** During the well-child visit for children ages 6-months up to 21 years, providers performed an oral health evaluation. If a patient was found to have active dental caries and not established with a dental provider, they were referred to the Tooth Tuesday clinic. The Tooth Tuesday clinic is held on the first Tuesday of every month from 8am to 12pm and is dedicated only to SDF application. In addition to the Tooth Tuesday referral, patients also received a referral to a dental provider for follow up and routine dental care.
- ***Scheduling:*** Patients referred to the Tooth Tuesday clinic received a phone call from the practice to schedule an SDF appointment time. Providers expressed that the Tooth Tuesday clinic tended to have a high number of missed appointments. One explanation discussed was that some families may choose to follow up directly with the referred dentist, believing that additional visits to the clinic are unnecessary after receiving a referral. As a result, the clinic is discussing transitioning away from the Tooth Tuesday clinic model and moving towards applying SDF in the same appointment that carious lesions are identified.
- ***Patient Consent Process:*** Consent for SDF application was obtained through a conversation between the provider and the child's caregiver and a signed form (Appendix B). Most of the patients in the observed pediatric practice were non-English speakers and when appropriate, the appointment was conducted through a phone interpreter. Before treatment, a standardized consent form was signed by the parent or guardian. Concerns about the staining effect of SDF were common. Concerns were typically resolved once it was clarified that the cavitated tooth was already darkened due to decay and that SDF would prevent further deterioration. In the case of primary teeth, it was also explained that the primary tooth would eventually exfoliate, allowing a healthy permanent tooth to replace it.



Patient Education

Education during the visit varied due to time constraints. Occasionally, a printed informational sheet about SDF was provided at the end of the appointment. In one of the visits did a child received a "Spruce the Dental Health Moose" oral health kit designed to promote dental hygiene. Despite these efforts, education on oral health and prevention strategies was limited.

Resident Education

During the Tooth Tuesday clinic, the attending physician would provide an overview of the SDF procedure, and the resident would shadow application. The resident participating in this case study reported feeling adequately prepared to apply SDF to a patient after observing two separate SDF applications.

Process Improvement

Decreasing missed appointments was identified as an area for needed improvement. Additionally, providers expressed the need for direct provider to dental office call lines to make more efficient referrals on the patient's behalf.

Residency Clinic by the Numbers:

Since June 2023-August 2025

- 44 individual patients received SDF
- 133 cavities treated with SDF
- 33% of patients received a second SDF application

During Observation Period

- Average time to review consent form - 4:02
- Average total SDF application time - 5:53 (with drying and multiple teeth)

SDF IMPLEMENTATION CASE STUDY 2: A RURAL HEALTH CENTER

MaineHealth Primary Care Damariscotta, located in Midcoast Maine, serves a largely rural patient population. In integrating SDF into the pediatric workflow, the practice determined applying SDF during the well-child check, if time allowed, was the best approach. While the observation period was meant to document SDF applications, no SDF applications were performed during the two-day shadowing period in summer 2025. However, this observation includes review of the oral health evaluation, fluoride varnish and clinical oral health education processes.

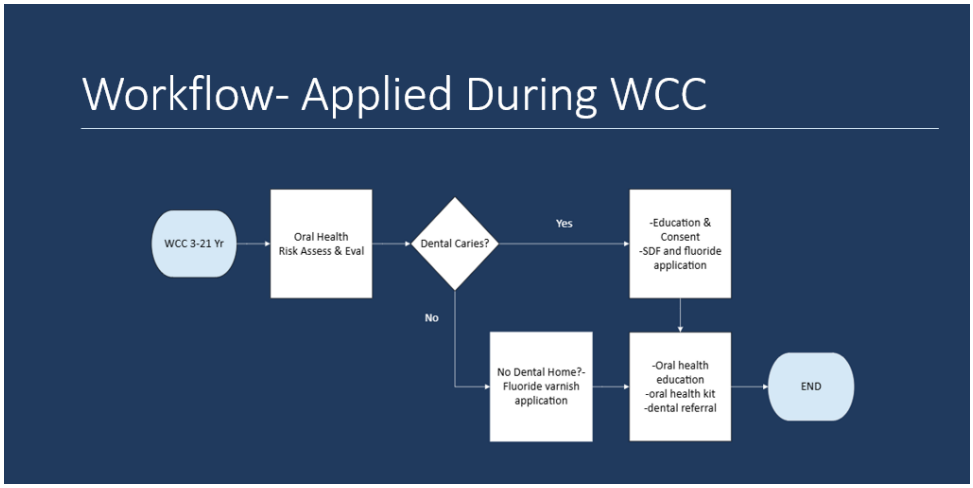
Setup

Clinic operations were well-organized and structured to support efficient pediatric care. Each examination room was stocked with oral health kits and dental referral lists. A locked medical closet held fluoride varnish, SDF application materials, and extra oral health kits.

Workflow

- **Well-Child Visits:** The provider reported anecdotally that while a majority of patients have reasonable access to dental care, a significant portion (mostly MaineCare or uninsured patients) have no or limited access to dental care. The pediatrician reported barriers to accessing dental care often include lack of transportation, financial barriers, and dental providers not accepting MaineCare insurance. During the shadowing days, the majority of families observed reported having an established relationship with a dental provider. For the patients who did not have a dental home, a dental referral list was provided, and parents and caregivers were encouraged to establish the patient with a dentist.

- **Identification and referrals:** During the appointment the provider conducted an oral health evaluation checking the teeth for signs of decay and carious lesions. None of the patients observed had active carious lesions that required SDF application. A few patients had white spots along the gum line indicating mineral loss. Early signs of decay were pointed out to the caregiver, documented in the EMR, fluoride varnish was applied if the caregiver consented, and a list of dental practices was provided. The importance of daily brushing and healthy diet were reinforced and the patient was provided with an oral health kit. Patients with early signs of decay will be evaluated at the next well-child visit to determine if SDF treatment is appropriate.



Provider Observations and Reflections

The provider expressed that a majority of her patient population tends to have reliable access to dental care. However, there is a minority with significant barriers as detailed above. The provider emphasized the importance of reinforcing oral health prevention to parents and caregivers and monitoring for early signs of dental decay, so early intervention can be offered when needed.

Rural Health Clinic by the Numbers:

- 18 patients have received SDF since June 2023 to August 2025

CONCLUSION

SDF is the next tool that primary care providers can add to their oral health toolbox to address access to oral health care. The observations collected in this report illustrate both the capability and limitations of integrating SDF into pediatric primary care. At sites serving higher-risk populations, SDF training equipped providers with the tools to confidently incorporate caries-arresting treatment into routine visits. Structured hands-on training, paired with ongoing access to online resources, facilitated provider learning, and supported workflow adaptation. The rural health center's lower incidence of caries and better dental access made in-clinic SDF treatment less common but still a useful option when needed. This highlights the importance of tailoring implementation strategies to the specific needs of each clinical context. Ultimately, these findings reinforce the value of SDF as a flexible, low-barrier intervention that, when thoughtfully integrated, can expand access to essential oral health care in pediatric settings.

APPENDIX A: OBSERVATION COLLECTION TOOL

Question	Notes
What does the arrival process look like?	
How is the setup? Where are the supplies stored?	
What are the topics for oral health education?	
Are they handing out Spruce the Moose kits?	
Was the patient scheduled for follow-up at the SDF clinic?	
What did the scheduling process look like	

Question	Notes
Is this the patient's first time at the SDF clinic?	
How long did the consent process take?	
How long did the SDF application take?	
Did they get a referral to a dental provider?	
Do they have a dental provider?	
Number of teeth treated?	
Is there an interpreter?	
What were the challenges of the application? (spitting, taste, age, etc.)	
What went well during the appointment?	

General notes:

APPENDIX B: SAMPLE CONSENT FORM

MaineHealth

MEDICAL TREATMENT
Page 1 of 2

Patient Name: _____

MRN: _____ DOB: _____

Treatment Location: _____

Dental Application of Silver Diamine Fluoride (SDF)

I agree to allow _____ to perform the following medical treatment:

Treatment for Cavities and to Prevent Cavities

Silver diamine fluoride (SDF) is applied to your child's teeth to stop tooth decay and decrease tooth discomfort. SDF is brushed onto the teeth. SDF causes the decayed part of the tooth to be permanently black. It does not hurt. It cannot be used if there are sores or raw areas on the gums. The teeth should remain dry for 1 minute after SDF is applied. You child cannot eat or drink for 1 hour after SDF is applied.

If a parent, guardian, or other authorized representative is signing this consent, the use of "I", "me", and "my" refer to the patient having the treatment.

My physician or a member of the team (who is a licensed designee) has explained the following.

About my treatment

- What to expect before, during, and after the treatment has been described to me.
- My treatment may involve removing tissue. MaineHealth will examine, store, and/or dispose of this tissue appropriately.
- I may have pain after my treatment. I may need to avoid my regular activities after my treatment.

About the risks, benefits, and alternatives

- The benefits of the treatment and why I am having it have been described to me.
- The risks of the treatment include: **Allergic reaction, metallic taste, staining of fillings, crowns, gums, skin, and the unhealthy part of teeth not under active treatment. The tooth decay progresses and requires further treatment, such as repeat SDF, fillings, crowns, root canals, and/or teeth removal.**

  _____
- There could be other risks that may be due to my other health conditions.
- Even if this treatment is done correctly, there is a chance I could have other problems. This includes severe bleeding, infection, cardiac arrest, or death.
- There are no guarantees about the outcome of the treatment.
- There are alternatives (other options) to having the treatment. The risks and benefits of these options have been explained to me.
- I can decide not to have the treatment. I understand the risks and benefits of this decision.

Other decisions

- There may be a representative (employee) from a medical device company present during the treatment. I will check the box if I do not agree.
  - ❑ I **DO NOT** allow a representative to be present during my treatment.
- There may be photos or video recordings made of my treatment or findings that will allow my physician to explain things to me better. These may be used to help teach others, for medical research, or in ways to improve care for other patients. These images will not contain information that could identify me. I will check the box if I do not agree.
  - ❑ I **DO NOT** allow my team to use images of me in medical journals, textbooks, or teaching sessions.