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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Initial Dental Exam**  **Unaccompanied Children’s Program**  **Office of Refugee Resettlement (ORR)** | | | | | | | | |
| **General Information** (to be completed by shelter staff) | | | | | | | | |
| **Child** | Last name: | | | | First name: | | | |
| DOB:  \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | | A#: | | | | Gender: | |
| **Healthcare Provider** | Name: | | | Phone number: | | Clinic or Practice: | | |
| Street address: | | | City or Town: | | State: | | Date of visit:  \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |
| **Program** | Name of program staff with child: | | | | Program name: | | | |
| **Assessment and Plan** (To be completed by healthcare provider) | | | | | | | | |
| **Assessment:**  Check all that apply and describe where applicable. | | | | | | | | |
| * No obvious problem | | | | | | | | |
| * Broken tooth or teeth: | | | | | | | | |
| * Gingivitis/gum disease: | | | | | | | | |
| * Impacted tooth or teeth: | | | | | | | | |
| * Infection or abscess: | | | | | | | | |
| * Tooth decay/caries:   If yes, how many? | | | | | | | | |
| * Tooth sensitivity: | | | | | | | | |
| * Other, specify: | | | | | | | | |
| **Plan:**  Check all that apply and specify in the space provided. | | | | | | | | |
| Return to clinic: | | | | | | | | |
| * PRN/As needed | | * Follow-up (specify condition, timing): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| * Medications given (specify name, reason, date started, dose, and directions and indicate if psychotropic):   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| * Procedure needed, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| * Referred to specialist; specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| * Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| **Additional Information:** | | | | | | | | |
|  | | | | | | | | |

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Page 1 of 1