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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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