OMB Control No: 0970-0466 Expiration date: XX-XX-XXXX

Initial Dental Exam Unaccompanied Children's Program Office of Refugee Resettlement (ORR) General Information (to be completed by shelter staff) Last name: First name: Child DOB: A#: Gender: Name: Phone number: Clinic or Practice: Healthcare **Provider** Street address: City or Town: State: Date of visit: Name of program staff with child: Program name: **Program** 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: € Follow-up (specify condition, timing): _ € PRN/As needed € 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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