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| **Dental Exam Form**  **Unaccompanied Children’s Program**  **Office of Refugee Resettlement (ORR)** | | | | | | | | | | | | | | | | | | |
| **General Information** | | | | | | | | | | | | | | | | | | |
| **Minor** | | Last name: | | | | | | | | | | | First name: | | | | | |
| DOB:  \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ | | | | | | A#: | | | | | | | | | Gender: | |
| **Dental Provider** | | Name: | | | | | | | Phone number: | | | | | | | Clinic or Practice: | | |
| Street address: | | | | | | | City or Town: | | | | | | State: | | | Date of visit:  \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_ |
| **Program** | | Program name: | | | | | | | | | | * Program Staff Member Present During Exam with Dental Provider | | | | | | |
| **Dental History** | | | | | | | | | | | | | | | | | | |
| **Concerns Expressed by Minor or Caregiver:** | | | | | | | | | | | | | | | | | | |
| **Diagnosis and Plan** | | | | | | | | | | | | | | | | | | |
| **Diagnosis:** Minor with complaints, symptoms, diagnoses/conditions; meds prescribed (including OTC) or referrals needed: | | | | | | | | | | | | | | | | | | |
|  | | | * No | * Yes, check all diagnoses that apply. Specify in the space provided, where indicated. | | | | | | | | | | | | | | |
| * Broken tooth or teeth | | | | | | | | | | | * Gingivitis/Gum disease | | | | | | | |
| * Impacted tooth/teeth | | | | | | | | | | | * Infection/Abscess | | | | | | | |
| * Tooth decay/Caries, specify how may: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | * 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
| Minor fit to travel: | | | * No | * Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | |
| Per program staff, discharge from ORR custody will be delayed: | | | | | | | | | | * No | | | | * Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Minor has/may have an ADA disability: | | | | | | * No | * Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | |
| * Referred to specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
| * Medications given (specify name, reason, date started, dose, and directions and indicate if psychotropic):   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
| * Dietary restrictions:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
| * Surgery/procedure needed/performed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | |
| * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |  | | --- | | **Recommendations from Healthcare Provider / Additional Information** | |  | | **Dental Provider Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_  **Dental Provider Printed Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | |

The purpose of this information collection is to provide ORR with critical health information for unaccompanied children in the care of ORR.Public reporting burden for this collection of information is estimated to average 5 minutes per healthcare provider, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. This is a mandatory collection of information (6 U.S.C. §279: Exhibit 1, part A.2 of the Flores Settlement Agreement (Jenny Lisette Flores, et al., v. Janet Reno, Attorney General of the United States, et al., Case No. CV 85-4544-RJK [C.D. Cal. 1996]). An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information subject to the requirements of the Paperwork Reduction Act of 1995, unless it displays a currently valid OMB control number. The OMB # is 0970-0466 and the expiration date is XX/XX/XXXX. If you have any comments on this collection of information, please contact [UACPolicy@acf.hhs.gov](mailto:UACPolicy@acf.hhs.gov).

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