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

Dental Assessment Form
Unaccompanied Children's Program
Office of Refugee Resettlement (ORR)

General Information

Child	Last name:		First name:		
	DOB:	A#:	Gender:	Date evaluated:	Time evaluated:
	Primary language: _____	Who provided appropriate language services for child during evaluation?	• HCP fluent in child's primary language	• Trained interpreter	• Not provided
Dental Provider	Name:	Phone number:	Clinic or Practice:		
	Street address:	City/Town:	State:		
Program	Program name:	• Program Staff Member Present During Exam with Dental Provider			
Reason for visit:	• Initial Dental Exam (IDE) • Follow-up for acute/chronic condition	• Acute dental care • Pre-surgical clearance	• Oral prophylaxis		

History and Assessment

Allergies: • No • Yes, specify below:

	Food	Medication	Environmental
Allergen			
Reaction			

Dental & Medical History (including dates & locations of care):

Surgeries: _____

Hospitalizations: _____

Chronic/Underlying conditions: _____

Family: _____

Currently pregnant: • No • Yes

Medications, (dosage frequency & dates): Past: _____ Current: _____

Concerns Expressed by Child or Caregiver: • No • Yes, specify:

Diagnosis and Plan

Diagnosis: Child with complaints, symptoms, diagnoses/conditions; meds prescribed (including OTC); referrals needed: • No • Yes, check all that apply

€ Broken tooth/ teeth € Gingivitis/Gum disease € Impacted tooth/teeth € Infection/Abscess € Missing tooth/teeth

€ Tooth decay/Caries € Tooth sensitivity € Other, specify: _____

Plan: Check all that apply and specify where indicated. **Please provide copies of office notes and lab/imaging results to program staff.**

- Child educated on healthcare services received and treatment recommendations

€ Medications administered/prescribed:

Medication name	Reason	Date started	Expected end date	Dose	Directions	Psychotropic
						• No • Yes
						• No • Yes
						• No • Yes

- Child has special healthcare needs that require accommodation while admitted in ORR care; specify condition/reason, time frame and frequency:
  - Dietary restrictions (e.g., soft foods, liquids): _____
  - Other: _____
- Child has/may have an ADA disability: _____
- Child is cleared for surgery
- Child has health concerns that require follow-up services; specify needs and time frame by when services should occur:
  - Return to clinic: _____
  - Specialist evaluation: _____

- Surgery/Procedure needed/performed: _____
- Other, specify: _____

Child cleared to travel:	• Yes, with no restrictions • Yes, with restrictions (e.g., ground travel, travel safety plan): _____ _____ • No, reason: _____

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 7 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.