

Dental Assessment Form (DAF)
Unaccompanied Alien Children Bureau
Office of Refugee Resettlement (ORR)

Instructions: This entire form must be completed by the evaluating dental provider by the conclusion of every assessment, including the Initial Dental Exam (IDE). Please refer to the DAF 'Dear Colleague' letter for additional guidance.

Child & Visit Information

Last name:	First name:	DOB:	Sex:
Visit type: • IDE • Restorative	• Preventive (incl. establish care visits) • Specialty care (e.g., oral surgery)	• Urgent care • Surgery clearance	Date evaluated: Time evaluated: AM / PM
Was an interpreter or translation service used in the performance of this assessment? • No • Yes, specify mode of service used: _____			
Chief complaint/History of present illness as reported by child and/or care provider staff (including current medications):			

Past Medical History (Required for the IDE only)

Relevant medical, dental, and surgical history (including substance use that may impact the child's oral health):

Allergies:

- No
- Yes, specify, including reaction: _____

• Food: _____

• Medication: _____

• Environmental: _____

Prophylactic antibiotics needed prior to dental procedures:

- No
- Yes, indication: _____

Assessment & Plan

Diagnoses:			
Diagnosis, including tooth #	Procedures done today (dental codes)	Referrals/Follow-up appts. (e.g., Oral Surgeon, PCP, Return to Clinic)	Timeframe/Date, if applicable

Plan: All fields required; please specify as indicated. **REMINDER: Please attach dental treatment plan!**

• No • Yes **Medications** prescribed or administered during visit (including OTCs and sedatives):

Medication Name & Dose	Admin Route	Frequency	Indication	Start Date	Duration	Refills

• No • Yes **Dietary restrictions** (e.g., soft foods, liquids) with timeframe: _____

• No • Yes **Child has pain, concern for infection or other dental issue interfering with daily activities** (e.g., eating, sleeping)

• No • Yes **Dental treatment required prior to surgery clearance:** _____

• No • Yes **Travel restrictions** (e.g., no travel, ground travel only): _____

PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13) STATEMENT OF PUBLIC BURDEN: 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 0.05 hours per respondent, 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 (see, 45 CFR §§410.1306(g);410.1307). 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 ORRDHUAC@acf.hhs.gov.

Additional Information:

Acknowledgment

I hereby confirm that the information that I have documented on this form is complete and accurate to the best of my ability. Furthermore, I agree to release all of the child's relevant health records to ORR, including but not limited to imaging results, treatment plans, and other pertinent documentation, to ensure continuity of care.

Healthcare Provider Signature: _____ **Date:** ____/____/____

Healthcare Provider Printed Name: _____ **Credentials:** _____ **Specialty:** _____

Clinic Name: _____ **Phone #:** _____