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)

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: