

**Initial Dental Exam  
 Unaccompanied Children's Program  
 Office of Refugee Resettlement (ORR)**

**General Information (to be completed by shelter staff)**

<b>Child</b>	Last name:	First name:		
	DOB: _____/_____/_____	A#: _____	Gender: _____	
<b>Healthcare Provider</b>	Name:	Phone number:	Clinic or Practice:	
	Street address:	City or Town:	State: _____	Date of visit: _____/_____/_____
<b>Program</b>	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:**

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