

## ORAL HEALTH PRELIMINARY EXAM AND PREVENTION SERVICES

Participation is voluntary, information collected on this form will be used for tracking treatment, and services provided to the patient and will be used only for this purpose. See instructions below.

Date of Preliminary Examination (mm/dd/yyyy)	Site	Initials - Examiner
--	------	---------------------

**PARTICIPATION INFORMATION**

Identification Number	Birth Date (mm/dd/yyyy)	Age
-----------------------	-------------------------	-----

<b>Gender</b> 1=Male 2=Female	<b>Race and Ethnicity</b> 1=White 2=African-American	3=Hispanic 4=Asian	5=American Indian/Alaska Native 6=Native Hawaiian/Pacific Islander	7=Multi-racial 9=Unknown
-------------------------------------	--	-----------------------	---	-----------------------------

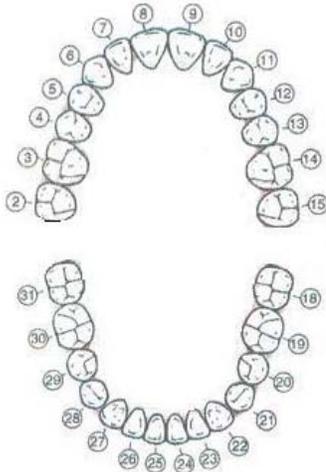
<b>Untreated Caries</b> 0=No untreated cavities 1=Untreated cavities	<b>Caries Experience</b> 0=No caries experience 1=Caries experience
--	---

<b>Edentulous</b> 0=No permanent teeth 1=At least one permanent tooth	<b>Treatment Urgency</b> 0=No obvious problem 1=Early dental care 2=Urgent care
---	--

Missing      Decayed      Filled



Comments:



**Caries Risk Assessment:** check all that apply, one or more indicates risk

**Clinical Conditions**

Untreated or treated caries	
Enamel demineralization (white spots)	
Gingivitis or visible plaque	
Wearing dental or orthodontic appliances	
Poorly formed enamel, deep pits	
Radiographic enamel caries	

**Environmental Characteristics**

Suboptimal systemic fluoride exposure	
Suboptimal topical fluoride exposure	
Frequent consumption of cariogenic foods/bev.	
Irregular or no usual source of dental care	
Economic or geographic barriers to dental care	

**Special Health Care Needs**

Special diets	
Behavioral problems	
Injuries related to seizure disorders or hyperactivity	
Inadequate oral hygiene due to mental capabilities, cognitive or motor delays	
Medications	
Neuromuscular (drooling, gag reflex, swallowing problems)	
Uncontrolled body movements	
Cardiac disorders	
Gastroesophageal reflux	
Visual impairment	
Latex allergies	

	No obvious problem	Refer 'R'	COMMENTS
Head and Neck			
Lymph Nodes			
Pharynx			
Tonsils			
Soft Palate			
Hard Palate			
Floor of Mouth			
Lips			
Skin			
TMJ			
Tongue			
Vestibules			
Buccal Mucosa			

**Community Water Fluoridation Status**

0=No      1=Yes

**Prescription Fluoride (prevedent, omni-gel etc.)**

0=No,  
1=Yes, currently uses \_\_\_\_\_

**Special Health Care Needs**

0=No      1=Yes

**Fluoride Varnish Application Indicated**

0=No      1=Yes

- Documented caries risk
- Has no contraindications to fluoride varnish (allergy, stomatitis)
- Documented parental permission

**Fluoride Varnish Application Schedule – Dosage .25 or .40**

1. Application Date \_\_\_\_\_ Provider Initials \_\_\_\_\_
2. Application Date \_\_\_\_\_ Provider Initials \_\_\_\_\_
3. Application Date \_\_\_\_\_ Provider Initials \_\_\_\_\_

**Referral services complete – Date \_\_\_\_\_ Initials \_\_\_\_\_**

**SIGNATURE – Dental Professional**

## INSTRUCTIONS

1. The **Site** is the name of the agency.
2. The **Identification Number** i.e., patient record number
3. For screening information refer to Basic Screening Surveys: An Approach to Monitoring Community Oral health, 1999, ASTDD, for completing the PARTICIPANT INFORMATION section of the form.
4. For caries risk assessment refer to Integrating Preventive Oral Health Measures into Healthcare Practice, Wisconsin Department of Health Services [http://dhs.wisconsin.gov/health/Oral\\_Health/trainingresources.htm](http://dhs.wisconsin.gov/health/Oral_Health/trainingresources.htm)
5. Address any questions to:  
**DEPARTMENT OF HEALTH SERVICES**  
**DLTC/BLTS/Community Integration**  
**Public Health Educator**  
**1 West Wilson Street, Room B138**  
**Madison WI 53702**