

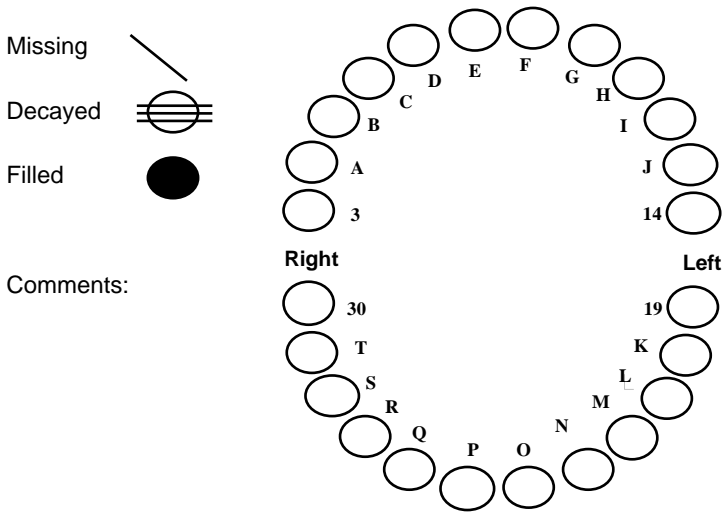
**PRESCHOOL ORAL HEALTH PRELIMINARY EXAM AND PREVENTION SERVICES**

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.

<b>Date of Preliminary Examination</b> (mm/dd/yyyy)	<b>Site</b>	<b>Initials - Examiner</b>
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<b>PARTICIPATION INFORMATION</b>		
<b>Identification Number</b>	<b>Birth Date (mm/dd/yyyy)</b>	<b>Age</b>
<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>Early Childhood Caries</b> 0=No ECC 1=ECC present	<b>Treatment Urgency</b> 0=No obvious problem 1=Early dental care 2=Urgent care



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

<b>Clinical Conditions</b>	
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	
<b>Environmental Characteristics</b>	
Suboptimal systemic fluoride exposure	
Suboptimal topical fluoride exposure	
Frequent consumption of cariogenic foods/ bev.	
Irregular or no usual source of dental care	
Low income	
Special health care needs	
Active caries present in the mother	
<b>General Health Conditions</b>	
Special health care needs	
Conditions impairing saliva composition/flow	

	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

**Dietary Fluoride Supplementation Status**  
 0=No, community or well is not fluoridated, not aware of fluoride level\*  
 \*Recommend water testing to determine fluoride level  
 1=Yes, currently uses dietary fluoride supplements  
 2=NA, community water or well has optimal fluoride level

**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

<b>Additional Comments:</b>	<p><b>Fluoride Varnish Application Schedule</b> - .25ml (preschool)</p> 1. Application Date _____ Provider Initials _____ 2. Application Date _____ Provider Initials _____ 3. Application Date _____ Provider Initials _____ <input type="checkbox"/> <b>Referral services complete</b> - Date _____ Initials _____
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**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 <https://www.dhs.wisconsin.gov/oral-health/trainings.htm>
5. Address any questions to:

**DEPARTMENT OF HEALTH SERVICES**  
**Division of Public Health**  
**State Dental Hygiene Officer**  
**1 West Wilson Street, Room 250**  
**Madison WI 53702**