

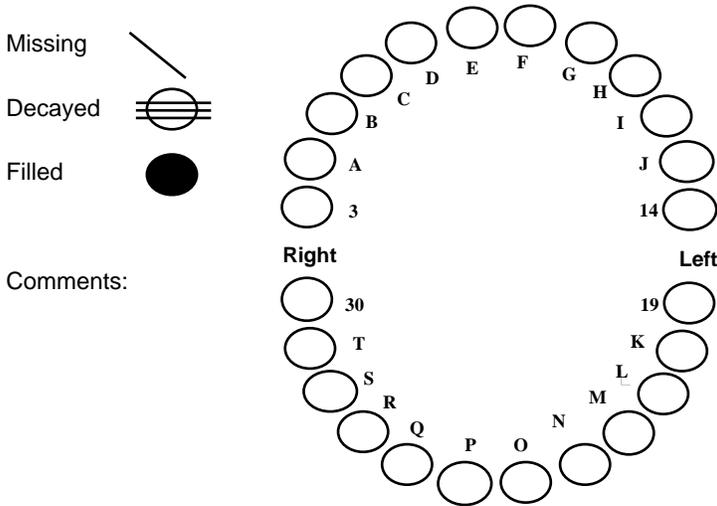
PRESCHOOL ORAL HEALTH PRELIMINARY EXAM AND PREVENTION SERVICES

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.

Date of Preliminary Examination (mm/dd/yyyy)	Site	Initials - Examiner
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PARTICIPATION INFORMATION		
Identification Number	Birth Date (mm/dd/yyyy)	Age
Gender 1=Male 2= Female	Race and Ethnicity 1=White 2=African-American 3=Hispanic 4=Asian 5= American Indian/Alaska Native 6=Native Hawaiian/Pacific Islander 7=Multi-racial 9=Unknown	

Untreated Caries 0=No untreated cavities 1=Untreated cavities	Caries Experience 0=No caries experience 1=Caries experience
Early Childhood Caries 0=No ECC 1=ECC present	Treatment Urgency 0=No obvious problem 1=Early dental care 2=Urgent care



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	
Low income	
Special health care needs	
Active caries present in the mother	
General Health Conditions	
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

Additional Comments:	Fluoride Varnish Application Schedule - .25ml (preschool) 1. Application Date _____ Provider Initials _____ 2. Application Date _____ Provider Initials _____ 3. Application Date _____ Provider Initials _____ <input type="checkbox"/> Referral services complete - 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 http://dhs.wisconsin.gov/health/Oral_Health/trainingresources.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