PORRT - NC Priority Oral Health Risk Assessment and Referral Tool

10905

Child's MID# ___ - ___ - _____

UNC Use Only ____

Child's Last Name

Today's date: MM / DD / YY

Child's First Name

Child's Middle Name

Child's Date of Birth: MM / DD / YYYY

Parent/Guardian's relationship to child: ○ Mom ○ Dad ○ Grandparent ○ Other:

PRACTICE NAME:

PROVIDER NAME:

A. Questions for Parent/Guardian

	Yes	No	Referral Recommendation
1. Do you brush your child's teeth at least once a day using toothpaste with fluoride?	☐	☐	**If 3 or more risk factors (shaded boxes) are marked, refer to a Dentist.**
2. Does your child drink fluoridated water?	☐	☐	
3. Does your child drink juice or sweetened drinks between meals or eat sugary snacks?	☐	☐	
4. Have you or anyone in your immediate family had dental problems?	☐	☐	
5. Does your child sleep with a bottle filled with drinks other than water?	☐	☐	

6. Is the child currently being seen by a dentist? ○ Yes ○ No

If yes, name of dentist: ____ Date of last appointment: MM / DD / YY

B. Questions for Provider Based on Clinical Assessment

	Yes	No	If Yes, Refer to a:
7. Does the child have any special health care needs?	☐	☐	Dentist
8. Does the child have cavities? (cavitated lesions)	☐	☐	Dentist
9. Does the child have visible plaque on the teeth?	☐	☐	Consider other risks
10. Does the child have enamel defects?	☐	☐	Dentist
11. Does the child have white spot lesions? (non-cavitated lesions)	☐	☐	Dentist
12. Does the child have other oral health conditions of concern?	☐	☐	Dentist

13. Please check procedures performed today: ☐ Oral Evaluation ☐ Fluoride Varnish ☐ Parent Education

14. Was the child referred to a dentist? ○ Yes ○ No

If YES, name of dentist: ____

Provider's Signature X _____

C. This section is to be completed by the Dental Office and faxed back to the referring physician

1. Date of dental appointment: MM / DD / YY

2. Did the patient show up for dental appointment? ○ Yes ○ No

3. Did patient call to cancel the appointment? ○ Yes ○ No

If yes, what reason was given? ____

4. Brief summary of dental findings: ____

5. Next dental appointment: MM / DD / YY Time: __ : __

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