

GIVE KIDS A SMILE! DAY DATE: _____	LOCATION _____	Arizona Dental Foundation 3193 N Drinkwater Scottsdale, AZ 85251 480-344-5777/800-866-2732	
	Last Name: _____	First Name: _____	Middle Initial: _____ Age: _____

PRESCREENING & TRIAGE

VISUAL SCREENING

Pain
 No Yes _____
 Get PA # _____

Infection
 No Yes _____ Please arrange for antibiotics prior to treatment.

VISUAL SCREENING RECOMMENDATIONS (initial) _____ (date) _____
 X-Rays Ordered _____
 Prophylaxis _____
 Fluoride _____
 Comments: _____

PRESCREENING RECOMMENDATIONS (initial) _____ (date) _____

- Sealants: _____ (list teeth)
- Extractions: _____ (list teeth)
- Restorations: _____ (list teeth)
- Pulp Therapy: _____ (list teeth)
- Other: _____ (list teeth)

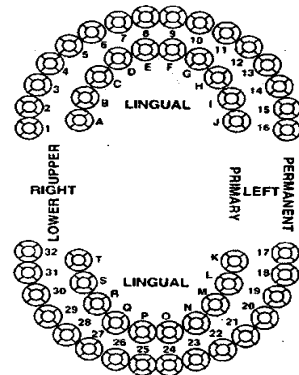
Screeener Name (print): _____ Title: _____

TRIAGE PRIORITIES (initial) _____ (date) _____

Indicate priority quadrant on diagram

- X-Rays Ordered _____
- Prophylaxis _____
- Fluoride _____
- Sealants: _____ (list teeth)
- Extractions: _____ (list teeth)
- Restorations: _____ (list teeth)
- Pulp Therapy: _____ (list teeth)
- Other: _____ (list teeth)

- Anesthesia Administered – See Patient Record
- Get PA # _____ then send to Oral Hygiene.



PATIENT CHECK-OUT

- Verify recommended/priority treatment was completed and patient record is signed.
- Confirm that patient has received the following take-home items: (initial) _____ (date) _____
 - Goody Bag with Toothbrush.
 - Aftercare Instructions (check off completed treatment and explain aftercare).
 - Pink Copy of Patient Record (circle follow-up recommendations).
 - Prescription if required.
 - Clean gauze for nurse/parent to change as needed.