El Rio Community Health Center
Integrated Health Home Program
Dental Report

PATIENT NAME: _____
DATE OF BIRTH: _____ **AGE OF PATIENT:** _____
PHYSICIAN NAME: _____
DENTAL CLINIC: *Southwest* _____ *Congress* _____ *Northwest* _____
NAME OF DENTAL PROVIDER: _____
DATE OF DENTAL SERVICES: _____

Dear El Rio Medical Provider:

Thank you for referring this patient to us as part of the Integrated Health Home Program (IHHP). The goal of the IHHP is to establish a collaborative physician/dentist health team in order to provide integrative medical/dental care for El Rio's pediatric patients. Your patient named above, was seen by an El Rio Dental provider. The following report contains the patient's dental diagnosis, dental services provided on the day of the examination as well as the follow-up dental treatment plan recommended for your patient to achieve optimum dental health. Please review this report with your patient's parents at their next medical appointment. This will re-enforce the need for good oral health as well as let the parents know that the El Rio medical/dental team is truly concerned and working together to improve the overall health of their child. If you have any questions or concerns, please feel free to contact the patient's dentist as contained in this report.

Diagnosis

Caries: YES NO Teeth with Caries: _____ Gingivitis: YES NO
Malocclusion: YES NO Other: YES NO If YES: _____

Treatment Provided	**Completed**	**Proposed**
Examination		
Caries Screening (under 3 y/o)		
Radiographs		
Cleaning		
Fluoride Varnish		
Oral Health Education		
Nutritional Counseling		

Follow-Up Treatment Plan

Number of the following treatment/s required:

Fillings: _____ Pulpotomies: _____ Crowns: _____ Extractions: _____

Other: _____

Recommended Dentist: Pediatric Dentist _____ General Dentist: _____ Orthodontist: _____
Other Treatment Options:

Oral Sedation _____ IV Sedation _____ GA _____ Ortho Consultation _____

Place of Treatment: El Rio _____ Other: _____
Recall Schedule: 3 month _____ 6 month _____ 1 year _____
Comments: _____

Signature of Providing Dentist: _____

To reach a dental provider, please dial "0"