D 0145 Maine Oral Health Risk Assessment and Referral Tool—Primary Care Version 20
For Children 0 to <3 Years Old

PRACTICE NAME				PHONE	FAX
Patient Name				Medical Record #	Today's Date
Date of Birth	Age	M	F	Provider Name	

Parent/Guardian Name_____
Relationship to Child ☐ **Mother** ☐ **Father** ☐ **Other**_____
Best Phone Number to Call

Dental Insurance ☐ **None/Self-Pay**
☐ **MaineCare ID#** _____
☐ **Other Insurance**

Section A: Oral Health Risk Assessment Questions

DENTAL HOME ASSESSMENT & CARIES RISK SCREENING QUESTIONS
May Be Administered by Clinical Support Staff

Q1. Does the child have teeth? ☐ **NO** → **STOP & Reassess at next well child visit** ☐ **YES** → **Continue to Q2 of Risk Questions (below)**	**Answers in shaded boxes below indicate Presence of Risk Factor***	
Q2. Has the child seen a dentist in the past year?	☐ **YES**	☐ **NO**
Q3. Does the child have his/her teeth brushed daily with toothpaste?	☐ **YES**	☐ **NO**
Q4. Has the child ever had cavities or fillings?	☐ **YES**	☐ **NO**
Q5. Has the mother/primary caregiver had active/untreated cavities in the past year?	☐ **YES**	☐ **NO**

Section B: Oral Evaluation and Plan

ORAL EVALUATION
Must Be Performed by Primary Care Provider

Q6. Is there visible plaque on the teeth?	☐ **YES**	☐ **NO**
Q7. Are there signs of visible decay or white spot lesions on the teeth?	☐ **YES**	☐ **NO**
Q8. Does the child have other oral conditions of concern (abscess, broken tooth, pain, etc.)?	☐ **YES**	☐ **NO**

ORAL HEALTH PLAN
Must Be Performed or Delegated by Primary Care Provider
***Consider fluoride varnish for one or more Risk Factors from Sections A and/or B**

Caries Risk Assessment
☐ **Low** (No Risk Factors)
☐ **Moderate/High** (1 or more Risk Factors)

For all children: ☐ Prescribed Fluoride Supplement (circle dose) **0.25mg 0.5mg 1.0mg** ☐ Fluoride Supplements not indicated
☐ Provided Oral Health Anticipatory Guidance ☐ Completed Caries Risk Assessment w/Oral Evaluation ☐ Other:
For children who have not seen a dentist in past year (Q2):
☐ Completed Caries Risk Assessment w/Oral Evaluation (D0145: For children enrolled in MaineCare <3 years of age)
☐ Applied Fluoride Varnish if moderate/high risk (D1206) ☐ Patient/Family declined Fluoride Varnish
☐ Referred Child to Dentist (see Section C)

Section C. Referral Information

This section to be completed by referring physician and faxed to dentist

Dentist Name	Phone	Fax

☐ Routine Referral
☐ Immediate Referral

This child has special health care needs. ☐ N/A
☐ Yes Explain:

There are factors that could hinder performing an oral health exam or X-rays for this child. ☐ N/A
☐ Oral sensitivities ☐ Difficulty following directions ☐ Latex allergies ☐ Difficulty swallowing
☐ Difficulty sitting still ☐ Does not tolerate knee-to-knee exam ☐ Food sensitivities ☐ Bruxism ☐ Other/Comments

Physician Name	Physician Signature	Date

This section to be completed by dentist and faxed back to referring physician

Date of Dental Appt.	Summary of Dental Findings/Plan

Dentist Signature Date