Dental Screening Report

Child's Name: _____ Date of Birth: _____/_____/_____

Screening Site: _____ Date of Screening: _____/_____/_____

Your child had a dental screening today. This is a quick look and check of the surface of your child's front, top and bottom teeth. Based on our oral health screening, **your child needs a full dental exam with a dentist**. Please schedule an appointment as soon as possible.

What we saw:

- ❑ White chalky spots
- ❑ Brown spots
- ❑ Broken tooth

White or brown spots on teeth may be a sign of tooth decay or a cavity. Only a dentist can determine if there is decay or a cavity and if further treatment in needed.

Please take this form to your child's dental exam. With your permission the dentist will complete the back of this form and return it to our office. This helps us to measure the accuracy and success of our dental screening program.

Thank you for working with us to ensure your child's healthy development!

For more information about your child's GROW Check and resources:

- Visit the Family Portal
- Email: support@getreadytogrow.org
- Phone: (585) 295-1008; Fax: (585) 295-1090
- Visit www.GetReadyToGROW.org for a list of dental providers

Get Ready to GROW
Supporting Kids' Healthy Development

Please take this form to the dentist

Dear Dentist,

Based on our oral health screening, the child listed below is being referred for a dental examination. Please have the parent sign below and fax this form to Get Ready to GROW at (585) 295-1090 with your professional findings. Thank you for helping to improve oral health for the children in our community!

I hereby give the dentist listed below permission to fax my child's dental exam to Children's Institute

_____ Date: _____/_____/_____
Parent/guardian signature

Child's Name: _____ Date of Birth: _____/_____/_____ Sex: ❍Male ❍Female

Screening Site: _____ Observations: _____

Date of Screening: _____/_____/_____

Results of Dental Exam Date of Exam: _____/_____/_____

Number of required additional appointments: _____

Plan of Treatment:

- ❑ Treatment plan without pharmacologic behavior management
- ❑ Treatment plan with Nitrous Oxide

Pending Faculty Approval for:

- ❑ Treatment plan with Oral Sedation
- ❑ Treatment plan under General Anesthesia
- ❑ Referred to other division(s) within EIOH _____

Narrative:

_____
_____
_____
_____

Examining Dentist Information

Name: _____
Address: _____
Phone: (_____) _____-_____
Fax: (_____) _____-_____

Please FAX this completed form to: (585) 295-1090 • Attn: Get Ready to GROW