Oral Health Screening Report & Referral Form (Spanish)
Instructions

Attached you will find the Spanish translation of the Oral Health Screening Report and Referral Form. When using the Spanish translation, parents/guardians and health care practitioners may find it helpful to have a copy of both the English and Spanish versions. Please note that some health care practitioners who do not speak or read Spanish may be reluctant to complete a form that they are unable to interpret.

The forms are set up in the same format as the English version. Please use the English version with the same date at the bottom of the form to assist with interpreting the form. For your convenience the English versions are included in the document following the Spanish versions.

The Oral Health Screening Report and Referral Form should be printed as a back and front document. The screening report will be page 1 and the referral portion of the form will be page 2.

Note: A copy of the completed oral health screening report and referral form that is sent to the student's parent/guardian should be maintained in the student's individual health record.

Page 1: Oral Health Screening Report
This page should be completed by the school nurse.

1. Enter the student's name, date of birth (DOB), and grade in the appropriate spaces.
2. Check the box to indicate the appropriate treatment urgency code based on the student's screening results.
3. Check the appropriate boxes that instruct the parent/guardian on the follow-up that is needed based on the student's treatment urgency. Check all of the boxes that apply.
4. Place your legible legal signature in the space labeled "Nurse (signature)."
5. Date the form in the appropriate space.
6. Print your name in the space labeled "Nurse (print)."
8. Enter the name of the school, school telephone number, and address in the appropriate spaces.

Page 2: Oral Health Screening Referral
The top portion should be completed by the school nurse.

1. Enter the student's name and the screening date in the appropriate spaces.
2. Check the box to indicate the appropriate treatment urgency code based on the student's screening results.
3. Provide a brief description of your findings during the screening.
4. Use the spaces in the box labeled "Parent/Guardian Follow-Up" to note parent/guardian contact and the date that the form was returned to you.
5. Space is provided for additional notes related to the referral.
6. Place your legible legal signature in the space labeled "Nurse (signature)."
7. Date the form in the appropriate space.
8. Enter the name of the school and school telephone number in the appropriate spaces.

The lower portion should be completed by the student's dentist.

Los niños sanos aprenden mejor	PROGRMA DE ESCUELAS SALUDABLES REPORTE DEL EXAMEN DE SALUD BUCAL

Nombre del estudiante:	Fecha de nacimiento:	Grado:

Estimado padre/madre/tutor:

Su niño tuvo un examen dental llevado a cabo por la enfermera de la escuela como parte de uno de los servicios proveídos por esta escuela. Este examen no sustituye al examen llevado a cabo por el dentista en el consultorio. El examen mostró que su niño:

- ❑ **Necesita cuidado dental urgente/de emergencia (dentro de 24 horas)**
  (Ver reverso de este formulario)
- ❑ **Necesita cuidado dental anticipado (dentro de varias semanas)**
  (Ver reverso de este formulario)
- ❑ **No hay problemas obvios (los chequeos rutinarios cada 6 meses deben seguir)**

La felicidad, capacidad de comer, concentración y éxito total de su niño en la escuela depende en parte de un reconocimiento temprano y tratamiento de la caries dental. Basado en el examen, nosotros recomendamos que usted:

- ❑ **Continúe con las visitas regulares con el dentista familiar.**
- ❑ **Haga una cita con el dentista de su niño, para que su niño sea revisado en un plazo de 24 horas.**
- ❑ **Haga una cita con el dentista de su niño para que su niño sea visto entre 3 a 4 semanas.**

Por favor:

- ❑ **Cuando lleve a su niño al dentista, lleve este formulario con usted.**
- ❑ **Pídale al dentista que escriba los resultados del examen en el reverso de este formulario.**
- ❑ **Tráigame el formulario completado a la escuela.**
- ❑ **Déjeme saber si su niño ya está recibiendo cuidado dental por este problema y la fecha en que fue visto por última vez por el dentista.**
- ❑ **<u>Por favor</u>, llámeme si tiene alguna pregunta o necesita ayuda para encontrar una clínica dental para su niño.**

Gracias por mantener a su niño saludable
Niños saludables aprenden mejor.

Firma de la enfermera:	Fecha:
Enfermera:	
Escuela:	Número de teléfono de la escuela:
Dirección de la escuela:	

Los niños sanos aprenden mejor

PROGRAMA DE SALUD ESCOLAR
CONTROL DE SALUD BUCAL DERIVACIÓN

Nombre del estudiante:	Fecha del control:

Razón de la derivación:
El control indicó:

- ❑ **Código 2 – Requiere atención dental urgente/de emergencia (dentro de 24 horas)**
- ❑ **Código 1 -- Requiere atención dental en fecha temprana (dentro de unas semanas)**
- ❑ **Código 0 – Ningún problema obvio (debería seguir con los chequeos dentales de rutina)**

Los códigos de urgencia de tratamiento son asignados según las pautas de la encuesta sobre Controles Dentales Básicos de la Asociación de Directores Dentales Estatales y Territoriales a http://www.astdd.org/index.php?template=basic_screening.html

Hallazgo hecho por la enfermera:

Seguimiento Con El Padre/Tutor (Contactos con el padre/tutor): Primera carta: Fecha: _____ Iniciales: _____ Llamada de seguimiento: Fecha: _____ Iniciales: _____ Devolución del formulario: Fecha: _____ Iniciales: _____	Apuntes adicionales:

Firma de la enfermera:	Fecha:
Escuela:	Teléfono:

Informe del Proveedor de Servicios de Salud Sobre las Conclusiones del Examen de Salud Bucal

Fecha del examen inicial:	**Fecha de la próxima cita:**

Recomendaciones / Tratamientos:

- ❑ Se identificaron y trataron las necesidades dentales inmediatas/de emergencia.
- ❑ Serán necesarias más citas de tratamiento.
- ❑ Sólo examen – ningún servicio extra fue prestado/necesario.
- ❑ El tratamiento está terminado. Vuelva al programa de exámenes dentales de rutina.

Hallazgos del examen:

Nombre del dentista (por favor, escriba en letra de molde):

Firma del dentista:

Teléfono del consultorio:	Fecha:

Healthy Children Learn Better	SCHOOL HEALTH PROGRAM ORAL HEALTH SCREENING REPORT

Student's Name:	DOB:	Grade:

Dear Parent/Guardian:

Your child had a dental screening performed by the school nurse as one of the services provided by this school. This screening does not take the place of an examination by a dentist in his/her office or clinic. The screening showed that your child has:

- ❑ **Urgent/Emergency Need for Dental Care (within 24 hours)**
  (see back of this form)
- ❑ **Early Dental Care Needs (within several weeks)**
  (see back of this form)
- ❑ **No Obvious Problems (routine dental checkups every 6 months should be continued)**

Your child's overall happiness, ability to eat, pay attention, and be successful at school depends, in part, on the early recognition and treatment of tooth decay. Based on the screening, we recommend that you

- ❑ **Continue with regular visits with your family dentist.**
- ❑ **Make an appointment for your child with his/her dentist so that your child can be seen within 24 hours.**
- ❑ **Make an appointment for your child with his/her dentist so that your child can be seen within 3 to 4 weeks.**

Please:

- ❑ **Take this form with you when you take your child to the dentist.**
- ❑ **Ask the dentist to fill out the results of the exam on the back of this form.**
- ❑ **Return the completed form to me at the school.**
- ❑ **Let me know if your child is already receiving dental care for this problem and the date that he/she was last seen by the dentist.**
- ❑ **<u>Please</u> call me if you have any questions or need help finding a dental home for your child.**

Thank you for keeping your child healthy.
Healthy children learn better.

Nurse (signature):	Date:
Nurse (print):	
School:	School Phone:
Address:	

Healthy Children Learn Better	SCHOOL HEALTH PROGRAM ORAL HEALTH SCREENING REFERRAL

Student's Name:	Screening Date:

Referral Status

The screening showed:

- ❑ **Code 2 - Urgent/Emergency Need for Dental Care (within 24 hours)**
- ❑ **Code 1 - Early Dental Care Needs (within several weeks)**
- ❑ **Code 0 - No Obvious Problems (routine dental checkups should be continued)**

The Treatment Urgency codes are assigned per the Association of State and Territorial Dental Directors Basic Screening Survey guidelines at http://www.astdd.org/index.php?template=basic_screening.html

Nurse's Findings:

Parent/Guardian Follow-Up (Contacts with parent/guardian) Initial letter: Date: _____ Initials: _____ Follow up call: Date: _____ Initials: _____ Form returned: Date: _____ Initials: _____	Additional notes:

Nurse's Signature:	Date:
School:	Telephone:

Health Care Provider's Report of Oral Health Examination Findings

Date of Initial Examination:	**Next appointment date:**

Recommendations / Treatments:

- ❑ Immediate/emergency dental needs were identified and treated.
- ❑ Additional treatment appointments will be necessary.
- ❑ Exam only – No additional services were rendered/necessary.
- ❑ Treatment is complete. Return to routine dental visit schedule.

Examination Findings:

Dentist's Name (please print):

Dentist's Signature:

Office Phone:	Date: