NSW Early Childhood Oral Health

Oral Health Advice Form
Fax No:

Insert AHS Logo

MRN (write number or stick on label)

CHILD'S DETAILS

Family Name: …… First Name: ……

Address: ……..

Child's Medicare No: …… Date of Birth: .....

Interpreter required: □ Yes □ No If yes, which language: ……..

Aboriginal and/or Torres Strait Islander: □ Yes □ No

PARENT/GUARDIAN DETAILS

Name: ……..

Relationship to child: ……..

Mobile Phone No: …….. Hm/Wk Phone No: ……

I give consent for the Public Oral Health Service to use this information.

Signature: …… **Date:** ……

□ Parent chooses to go privately (please obtain parental consent to forward this form to oral health services for de-identified Lift the Lip reporting purposes only)

ORAL HEALTH ASSESSMENT*(tick boxes)*	**ACTION**
□ Recent trauma (not yet seen by dentist or dental therapist) or facial swelling	1. Immediate transfer to Dental Call Centre **<call centre phone number>** 2. Send advice form (see below)
□ White spot demineralisation	Send this advice form to Early Childhood Oral Health Coordinator **<phone/fax number/email>**
□ Cavitated lesions (holes)	
□ Family requires oral health support	
□ Frequent snacking (especially high sugar intake)	Discuss with parent and record findings Re-assess at next scheduled health check
□ Child takes a bottle to bed (or uses at will by day)	
□ Special health needs / frequent medications	
□ Visible plaque	

REFERRED BY (Print name and title): ……..

Phone No: …….. Fax No: ……

Email: ……

Postal Address (if required for feedback): ……..

NOTES: ……

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