

Dental Assessment Form for Children in Care

AREA

Purpose of this form:

- To ensure Children in Care receive an initial dental assessment and ongoing dental care
- To allow an oral health plan to be incorporated into the child's overall health plan
- To ensure appropriate ongoing dental care for the child, even if they move out of area.

Who should complete the form?

Section 1 should be completed by the carer prior to the dental assessment. Sections 2, 3 and 4 should be completed by the dentist at the child's dental appointment.

For the carer:

- Please arrange a dental assessment for the child as soon as possible
- Complete section 1 of this form prior to the dental visit and take it with you to the appointment
- **Please ensure that you bring any paperwork related to consent/delegated authority to the child's dental appointment**
- If the dental appointment is prior to the child's initial health assessment (IHA) then please take the completed form with you to the IHA appointment. If the dental appointment is following the IHA, then please return the form by post to the **Children in Care Health Team, ADDRESS**
- A copy of this form should also be completed prior to a child's review health assessment (RHA). If the dental appointment is before the RHA, the form should be taken to the RHA appointment. If the dental appointment is after the RHA please return to: **Children in Care Health Team, ADDRESS**

For the dentist:

A child becomes a Child in Care if they are in the care of the local authority for more than 24 hours. Children can be in care by agreement with parents or by court order. Children in Care have regular health assessments to ensure their health needs are being met. The dental assessment you undertake will help inform their overall health assessment.

Informed consent for dental treatment is needed from an adult with parental responsibility for the child (unless the child can consent for themselves). Section 1 of this form provides the child's details and social worker details which we advise you record. Should you have any questions surrounding consent please contact the named social worker for further support.

For Children in Care who require orthodontic assessment or who present mid-orthodontic treatment and are unable to return to their original orthodontist, please refer to the local secondary care orthodontic unit via ERMS- **Yorkshire and Humber only**

Please complete page 2 and 3 of the form and return to the carer at the same visit

This information is confidential and is not to be divulged without authorisation. A copy of this form will be shared with health and local authority teams as appropriate.

1. Child/young person's details – to be completed by carer before appointment			
First Name(s):		Family Name:	
Date of Birth:		NHS Number (if known):	
Current Carer:			
Current Carer Contact Details:			
Named Social Worker:			
Social Worker Contact Details:			

2. Dental practice details- to be completed by dentist	
Dentist name:	
E-mail address (nhs.net):	
Practice telephone number:	
Practice address (please use practice stamp if available):	

3. Dental Assessment		Date:		
Dental/oral findings (please tick all which apply):				
No dental/oral disease noted	<input type="checkbox"/>			
Gingivitis (gum inflammation)	<input type="checkbox"/>			
Decay affecting primary (baby) teeth	<input type="checkbox"/>	Number of teeth affected.....		
Decay affecting permanent (adult) teeth	<input type="checkbox"/>	Number of teeth affected.....		
Other <i>including dental pain and infection</i> (please avoid use of abbreviations to aid review by non-dental professionals):				
Are x-rays available? (please circle)	Yes	No	Date and type of images:	

4. Treatment Plan

Please tick all that apply:

- Oral health advice
- Fillings of primary (baby) teeth Number of baby teeth planned to fill.....
- Fillings of permanent (adult) teeth Number of adult teeth planned to fill.....
- Extractions of primary (baby) teeth Number of baby teeth planned to extract....
- Extractions of permanent (adult) teeth Number of adult teeth planned to extract.....

Other (please avoid use of abbreviations to aid review by non-dental professionals):

Has the above treatment been completed at today's appointment? (Please circle)	Yes	No
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Has a further appointment been made with your practice? (Please circle)	Yes	No
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If yes please provide date(s) and details	
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Has/will a referral be made to any other dental providers e.g. Community Dental Service, Orthodontics? (Please circle)	Yes	No
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If yes please provide details of provider referred to:	
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Please state planned recall interval (months):	
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Please circle to confirm that recall has been discussed and agreed by carer/ parent	Yes	No
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Signature of dentist completing assessment					
Signature:		Print Name:		Date:	

We thank you for your support