



# CHDP Dental Training: Oral Health Assessment and Referral Review Questions – ANSWER KEY

(Correct answers are highlighted and discussion points for CHDP staff are under each photo.)

1. At what age should a child be referred for their first dental visit? Begin no later than Age One and refer at any age if a problem is detected or suspected.
2. How often should a child in CHDP see a dentist for a routine dental exam and preventive dental treatment? Children in CHDP are considered moderate to high risk for dental decay and should be referred to a dentist every six months.
3. How would you classify and document the following dental assessment?  
(Document on the PM160 form below.)



Healthy gums, no inflammation and no visible white, brown or black spots on teeth.



Refer to the dentist for routine dental care.

PLEASE PRINT	PATIENT NAME (LAST)	(FIRST)	(INITIAL)	MEDICAL RECORD NO.	LA Code	94	XXXXXXXXX J
	BIRTHDATE (Mo., Day, Year)	AGE	SEX M/F	PATIENT'S COUNTY OF RESIDENCE	CO. CODE	TELEPHONE NUMBER	NEXT CHDP EXAM (Mo., Day, Year)
	RESPONSIBLE PERSON (NAME)	(STREET)	(APT./SPACE #)	(CITY)	(ZIP)	Ethnic Code <input type="checkbox"/> 1-American Indian <input type="checkbox"/> 2-Asian <input type="checkbox"/> 3-Black <input type="checkbox"/> 4-Filipino <input type="checkbox"/> 5-Mex. Amer./Hispanic <input type="checkbox"/> 6-White <input type="checkbox"/> 7-Other <input type="checkbox"/> 8-Pacific Islander	
<b>CHDP ASSESSMENT</b> Indicate outcome for each screening procedure		NO PROBLEM SUSPECTED <input checked="" type="checkbox"/> A	REFUSED, CONTRA-INDICATED, NOT NEEDED <input checked="" type="checkbox"/> B	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column		DATE OF SERVICE Mo. Day Year	
		NEW C	KNOWN D	FEES		FOLLOW UP CODES	
01 HISTORY and PHYSICAL EXAM						1. NO DX/RX INDICATED OR NOW UNDER CARE. 2. QUESTIONABLE RESULT, RECHECK SCHEDULED. 3. DX MADE AND RX STARTED	
02 DENTAL ASSESSMENT/REFERRAL						4. DX PENDING/RETURN VISIT SCHEDULED. 5. REFERRED TO ANOTHER EXAMINER FOR DX/RX. 6. REFERRAL REFUSED	
03 NUTRITIONAL ASSESSMENT						<b>COMMENTS/PROBLEMS</b> IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA	
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION							
05 DEVELOPMENTAL ASSESSMENT							
06 SNELLEN OR EQUIVALENT					06		
07 AUDIOMETRIC					07		
08 HEMOGLOBIN OR HEMATOCRIT					08		
09 URINE DIPSTICK					09		
10 COMPLETE URINALYSIS					10		
12 TB MANTOUX					12		
CODE OTHER TESTS		PLEASE REFER TO THE CHDP LIST OF TEST CODES			CODE		
HEIGHT IN INCHES	WEIGHT LBS	BODY MASS INDEX (BMI) PERCENTILE	BLOOD PRESSURE		ROUTINE REFERRAL(S) <input checked="" type="checkbox"/> DENTAL <input checked="" type="checkbox"/>		
0	4						
HEMOGLOBIN	HEMATOCRIT	BIRTH WEIGHT LBS	GIVEN TODAY		DIAGNOSIS CODES		
			NOT GIVEN TODAY				
IMMUNIZATIONS PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES				NOW UP TO DATE FOR AGE	STILL NOT UP TO DATE FOR AGE	ALREADY UP TO DATE FOR AGE	REFUSED OR CONTRA-INDICATED



5. How would you classify and document the following dental assessment?  
(Fill in the PM160 form below.)



Beginning decay - white chalky decalcification near the gum line. Apply fluoride varnish and refer to a dentist.



Dark areas in the enamel where two teeth meet and on the chewing surfaces. Condition is not urgent but requires a dental referral.

CLAIM CONTROL NUMBER • FOR STATE USE ONLY		<b>8</b> STAPLE HERE																																																																																						
DO NOT STAPLE IN BAR AREA																																																																																								
PATIENT NAME (LAST) (FIRST) (INITIAL) MEDICAL RECORD NO. LA Code _____ 94 XXXXXXXX J		Ethnic Code <input type="checkbox"/> 1-American Indian <input type="checkbox"/> 2-Asian <input type="checkbox"/> 3-Black <input type="checkbox"/> 4-Filipino <input type="checkbox"/> 5-Mex. Amer./Hispanic <input type="checkbox"/> 6-White <input type="checkbox"/> 7-Other <input type="checkbox"/> 8-Pacific Islander																																																																																						
BIRTHDATE (Mo. Day Year) AGE SEX M/F PATIENT'S COUNTY OF RESIDENCE CO. CODE TELEPHONE NUMBER NEXT CHDP EXAM (Mo. Day Year) RESPONSIBLE PERSON (NAME) (STREET) (APT./SPACE #) (CITY) (ZIP)																																																																																								
<b>CHDP ASSESSMENT</b> Indicate outcome for each screening procedure		<b>FOLLOW UP CODES</b> 1. NO DX/RX INDICATED OR NOW UNDER CARE. 2. QUESTIONABLE RESULT, RECHECK SCHEDULED. 3. DX MADE AND RX STARTED 4. DX PENDING/RETURN VISIT SCHEDULED. 5. REFERRED TO ANOTHER EXAMINER FOR DX/RX. 6. REFERRAL REFUSED																																																																																						
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th rowspan="2">CHDP ASSESSMENT</th> <th rowspan="2">NO PROBLEM SUSPECTED ✓ A</th> <th rowspan="2">REFUSED, CONTRA-INDICATED, NOT NEEDED ✓ B</th> <th colspan="2">PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column</th> <th rowspan="2">DATE OF SERVICE Mo. Day Year</th> <th rowspan="2">FEES</th> </tr> <tr> <th>NEW C</th> <th>KNOWN D</th> </tr> </thead> <tbody> <tr> <td>01 HISTORY and PHYSICAL EXAM</td> <td></td> <td></td> <td></td> <td></td> <td>01</td> <td></td> </tr> <tr> <td>02 DENTAL ASSESSMENT/REFERRAL</td> <td></td> <td></td> <td style="background-color: yellow;">5</td> <td></td> <td></td> <td></td> </tr> <tr> <td>03 NUTRITIONAL ASSESSMENT</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>04 ANTICIPATORY GUIDANCE HEALTH EDUCATION</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>05 DEVELOPMENTAL ASSESSMENT</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>06 SNELLEN OR EQUIVALENT</td> <td></td> <td></td> <td></td> <td></td> <td>06</td> <td></td> </tr> <tr> <td>07 AUDIOMETRIC</td> <td></td> <td></td> <td></td> <td></td> <td>07</td> <td></td> </tr> <tr> <td>08 HEMOGLOBIN OR HEMATOCRIT</td> <td></td> <td></td> <td></td> <td></td> <td>08</td> <td></td> </tr> <tr> <td>09 URINE DIPSTICK</td> <td></td> <td></td> <td></td> <td></td> <td>09</td> <td></td> </tr> <tr> <td>10 COMPLETE URINALYSIS</td> <td></td> <td></td> <td></td> <td></td> <td>10</td> <td></td> </tr> <tr> <td>12 TB MANTOUX</td> <td></td> <td></td> <td></td> <td></td> <td>12</td> <td></td> </tr> </tbody> </table>		CHDP ASSESSMENT	NO PROBLEM SUSPECTED ✓ A	REFUSED, CONTRA-INDICATED, NOT NEEDED ✓ B	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column		DATE OF SERVICE Mo. Day Year	FEES	NEW C	KNOWN D	01 HISTORY and PHYSICAL EXAM					01		02 DENTAL ASSESSMENT/REFERRAL			5				03 NUTRITIONAL ASSESSMENT							04 ANTICIPATORY GUIDANCE HEALTH EDUCATION							05 DEVELOPMENTAL ASSESSMENT							06 SNELLEN OR EQUIVALENT					06		07 AUDIOMETRIC					07		08 HEMOGLOBIN OR HEMATOCRIT					08		09 URINE DIPSTICK					09		10 COMPLETE URINALYSIS					10		12 TB MANTOUX					12		REFERRED TO: _____ TELEPHONE NUMBER _____ Dentist name and Phone Number REFERRED TO: _____ TELEPHONE NUMBER _____
CHDP ASSESSMENT	NO PROBLEM SUSPECTED ✓ A				REFUSED, CONTRA-INDICATED, NOT NEEDED ✓ B	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column			DATE OF SERVICE Mo. Day Year	FEES																																																																														
		NEW C	KNOWN D																																																																																					
01 HISTORY and PHYSICAL EXAM					01																																																																																			
02 DENTAL ASSESSMENT/REFERRAL			5																																																																																					
03 NUTRITIONAL ASSESSMENT																																																																																								
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION																																																																																								
05 DEVELOPMENTAL ASSESSMENT																																																																																								
06 SNELLEN OR EQUIVALENT					06																																																																																			
07 AUDIOMETRIC					07																																																																																			
08 HEMOGLOBIN OR HEMATOCRIT					08																																																																																			
09 URINE DIPSTICK					09																																																																																			
10 COMPLETE URINALYSIS					10																																																																																			
12 TB MANTOUX					12																																																																																			
HEIGHT IN INCHES _____ WEIGHT LBS _____ OZS _____ BODY MASS INDEX (BMI) PERCENTILE _____ BLOOD PRESSURE _____ HEMOGLOBIN _____ HEMATOCRIT _____ BIRTH WEIGHT LBS _____ OZS _____		ROUTINE REFERRAL(S) (✓) <input type="checkbox"/> PATIENT IS A FOSTER CHILD (✓) <input type="checkbox"/> BLOOD LEAD <input type="checkbox"/> DENTAL <input type="checkbox"/>																																																																																						
<b>IMMUNIZATIONS</b> PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES		DIAGNOSIS CODES 1 _____ 2 _____																																																																																						
GIVEN TODAY (NOW UP TO DATE FOR AGE A) STILL NOT UP TO DATE FOR AGE B ALREADY UP TO DATE FOR AGE C REFUSED OR CONTRA-INDICATED D		<b>THE QUESTIONS BELOW MUST BE ANSWERED</b>																																																																																						
PATIENT VISIT (✓) _____ TYPE OF SCREEN (✓) _____ TOTAL FEES _____		1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes <input type="checkbox"/> No <input type="checkbox"/> 2. Tobacco Used by Patient Yes <input type="checkbox"/> No <input type="checkbox"/> 3. Counseled About/Referred For Tobacco Use Prevention/ Yes <input type="checkbox"/> No <input type="checkbox"/>																																																																																						

6. How would you classify and document the following dental assessment?  
(Fill in the PM160 form below.)



Acute trauma to tooth or gums.  
Refer child to a dentist immediately.



Swelling from oral infection usually found near the root of the tooth inside the mouth and may be visible on the face – Immediate referral.

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

DO NOT STAPLE IN BAR AREA

8  
STAPLE  
HERE

PATIENT NAME (LAST) (FIRST) (INITIAL)			MEDICAL RECORD NO.			LA Code		94 XXXXXXXX J	
BIRTHDATE (Mo. Day Year)		AGE	SEX M/F	PATIENT'S COUNTY OF RESIDENCE		CO. CODE	TELEPHONE NUMBER		NEXT CHDP EXAM (Mo. Day Year)
RESPONSIBLE PERSON (NAME)			(STREET)			(APT./SPACE #)	(CITY)		(ZIP)

CHDP ASSESSMENT Indicate outcome for each screening procedure	NO PROBLEM SUSPECTED ✓ A	REFUSED, CONTRA-INDICATED, NOT NEEDED ✓ B	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column		DATE OF SERVICE Mo. Day Year	FEEES	FOLLOW UP CODES	
			NEW C	KNOWN D			1. NO DX/RX INDICATED OR NOW UNDER CARE	4. DX PENDING/RETURN VISIT SCHEDULED
01 HISTORY and PHYSICAL EXAM								
02 DENTAL ASSESSMENT/REFERRAL				5				
03 NUTRITIONAL ASSESSMENT								
04 ANTICIPATORY GUIDANCE HEALTH EDUCATION								
05 DEVELOPMENTAL ASSESSMENT								
06 SNELLEN OR EQUIVALENT								
07 AUDIOMETRIC								
08 HEMOGLOBIN OR HEMATOCRIT								
09 URINE DIPSTICK								
10 COMPLETE URINALYSIS								
12 TB MANTOUX								

Dentist name and Phone Number

02 Class IV Acute injury, oral infection or other painful condition (broken tooth, swollen jaw) - Immediate Referral. 5

HEIGHT IN INCHES	WEIGHT LBS	OZS	BODY MASS INDEX (BMI) PERCENTILE	BLOOD PRESSURE
0	4			
HEMOGLOBIN	HEMATOCRIT		BIRTH WEIGHT LBS	OZS

IMMUNIZATIONS PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES		GIVEN TODAY	NOT GIVEN TODAY	
NOW UP TO DATE FOR AGE	A	STILL NOT UP TO DATE FOR AGE	B	ALREADY UP TO DATE FOR AGE
				C
				REFUSED OR CONTRA-INDICATED
				D

ROUTINE REFERRAL(S) (✓)	PATIENT IS A FOSTER CHILD (✓)
<input type="checkbox"/> BLOOD LEAD	<input type="checkbox"/> DENTAL

DIAGNOSIS CODES	
1	2

THE QUESTIONS BELOW MUST BE ANSWERED

1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes  No
2. Tobacco Used by Patient. Yes  No
3. Counseled About/Referred For Tobacco Use Prevention/ Yes  No

PATIENT VISIT (✓)	TYPE OF SCREEN (✓)	TOTAL FEES
-------------------	--------------------	------------