

*CHDP Dental Training: Focus on PM 160 Screening*  
Evaluation Form



Date: \_\_\_\_\_ Office/Clinic: \_\_\_\_\_ County: \_\_\_\_\_

I am a:  Physician  Nurse  Nurse Practitioner  Physician Assistant  MA

Other Staff (specify) \_\_\_\_\_ Dental Professional (specify) \_\_\_\_\_

1. Are you more confident classifying the dental condition of your patients and documenting on the PM160?

YES  NO  Need More Training

Comment: \_\_\_\_\_

2. Will you refer children to the dentist at least annually beginning at age one?

YES  NO  Need More Training

Comment: \_\_\_\_\_

3. Do you need clarification/additional training on any of the following? (Check all that apply)

- Risk Assessment  Fluoride Assessment  Oral Assessment  
 Anticipatory Guidance  Documentation  Referral  
 Fluoride Varnish Application

Comment: \_\_\_\_\_

4. Would you recommend this presentation to other health care providers?

YES  NO

If no, what would make this presentation better?

\_\_\_\_\_

5. If you would like more dental resources/training please give your contact information:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Email \_\_\_\_\_

**Thank you!**