

*CHDP Dental Training: Oral Health Assessment and Referral  
Evaluation Form*



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

I am a:  Physician  Nurse Practitioner  Nurse  Physician Assistant  MA  
Other Staff (specify) \_\_\_\_\_ Dental Professional (specify) \_\_\_\_\_

1. After this presentation, are you more confident in your ability to perform an oral health assessment?  
 YES  NO  Need More Training

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

2. Will you refer children to the dentist at least annually beginning at age one?  
 YES  NO

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

3. Are you more confident classifying the dental condition of your patients and documenting on the PM160?  
 YES  NO

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

4. Will you offer fluoride varnish application for children under 6 who are at risk for dental caries?  
 YES  NO

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

5. Would you like additional training on fluoride varnish application?  
 YES (provide contact information below)  NO

6. Do you need clarification on any of the following sections of the training? (Check all that apply)  
 Risk Assessment  Fluoride Assessment  Oral Assessment  
 Anticipatory Guidance  Documentation  Referral

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

7. Which guides and brochures referenced in this training will you download and/or print:

Guides:  Oral Health for Infants & Toddlers  PM160 Dental Guide  
 CHDP/CCS Orthodontic & Craniofacial Referral Guide

Brochures:  Fluoride Varnish  Growing Up Healthy (14 age specific brochures)  
 Every Child Needs a Dental Home  Prevent Tooth Decay in Babies and Toddlers

Other: \_\_\_\_\_

8. Would you recommend this presentation to other health care providers?  
 YES  NO

If no, what would make this presentation better? \_\_\_\_\_

\_\_\_\_\_

9. If you would like more dental resources please give your contact information:

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

Thank you!