

CHDP Dental Training: Focus on PM 160 Screening Review Questions



- At what age should a child be referred for their first dental visit?
- How often should a child in CHDP see a dentist for a routine dental exam and preventive dental treatment?
- How would you classify and document the following dental assessment?
(Fill in the PM160 form below.)



DO NOT STAPLE
IN BAR AREA

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

8
STAPLE
HERE

PLEASE PRINT	PATIENT NAME (LAST) (FIRST) (INITIAL)			MEDICAL RECORD NO.		LA Code		94 XXXXXXXX J	
	Mo.	Day	Year	AGE	SEX M/F	PATIENT'S COUNTY OF RESIDENCE		CO. CODE	TELEPHONE NUMBER
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	

CHDP ASSESSMENT <small>Indicate outcome for each screening procedure</small>	NO PROBLEM SUSPECTED	REFUSED, CONTRA-INDICATED, NOT NEEDED	PROBLEM SUSPECTED <small>Enter Follow Up Code in Appropriate Column</small>		DATE OF SERVICE <small>Mo. Day Year</small>	FEES	FOLLOW UP CODES	
			NEW	KNOWN			1. NO DX/RX INDICATED OR NOW UNDER CARE.	4. DX PENDING/RETURN VISIT SCHEDULED.
01 HISTORY and PHYSICAL EXAM	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	01		2. QUESTIONABLE RESULT, RECHECK SCHEDULED.	5. REFERRED TO ANOTHER EXAMINER FOR DX/RX.
02 DENTAL ASSESSMENT/REFERRAL	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			3. DX MADE AND RX STARTED	6. REFERRAL REFUSED
03 NUTRITIONAL ASSESSMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			COMMENTS/PROBLEMS IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA	
04 ANTICIPATORY GUIDANCE <small>(HEALTH EDUCATION)</small>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
05 DEVELOPMENTAL ASSESSMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
06 SNELLEN OR EQUIVALENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	06			
07 AUDIOMETRIC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	07			
08 HEMOGLOBIN OR HEMATOCRIT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	08			
09 URINE DIPSTICK	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	09			
10 COMPLETE URINALYSIS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	10			
12 TB MANTOUX	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12			
CODE	OTHER TESTS	PLEASE REFER TO THE CHDP LIST OF TEST CODES				CODE		

HEIGHT IN INCHES	WEIGHT LBS	OZS	BODY MASS INDEX (BMI) PERCENTILE	BLOOD PRESSURE	
0	4				
HEMOGLOBIN	HEMATOCRIT			BIRTH WEIGHT LBS	
		.0%	%	OZS	
		GIVEN TODAY		NOT GIVEN TODAY	
		NOW UP TO DATE FOR AGE	STILL NOT UP TO DATE FOR AGE	ALREADY UP TO DATE FOR AGE	REFUSED OR CONTRA-INDICATED

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

DIAGNOSIS CODES	
1	2

IMMUNIZATIONS
PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES

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



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02 DENTAL ASSESSMENT/REFERRAL								REFERRED TO:		TELEPHONE NUMBER																												
03 NUTRITIONAL ASSESSMENT								COMMENTS/PROBLEMS 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	OTHER TESTS																														
HEIGHT IN INCHES		WEIGHT LBS OZS		BODY MASS INDEX (BMI) PERCENTILE		BLOOD PRESSURE		ROUTINE REFERRAL(S) <input type="checkbox"/> <input type="checkbox"/> PATIENT IS A FOSTER CHILD <input type="checkbox"/> <input type="checkbox"/> BLOOD LEAD <input type="checkbox"/> DENTAL																														
HEMOGLOBIN		HEMATOCRIT		%		BIRTH WEIGHT LBS OZS																																
								DIAGNOSIS CODES 1 2																														
IMMUNIZATIONS PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES		GIVEN TODAY		NOT GIVEN TODAY				THE QUESTIONS BELOW MUST BE ANSWERED 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"/>																														
		NOW UP TO DATE FOR AGE A		STILL NOT UP TO DATE FOR AGE B		ALREADY UP TO DATE FOR AGE C																																
PATIENT VISIT <input checked="" type="checkbox"/>		TYPE OF SCREEN <input checked="" type="checkbox"/>		TOTAL FEES																																		