

Maryland's Mouths Matter Fluoride Varnish and Oral Health Screening Program for Kids
Referral Form

Date of Visit: ____/____/____

Patient Name: _____

Patient DOB: ____/____/____

Patient Medicaid ID #: _____

Parent/Guardian Name: _____

Parent/Guardian Phone #: _____

Practice/Provider Name: _____

PLEASE CIRCLE YOUR RESPONSE.

TEETH AND CONDITIONS PRESENT

How many teeth are present?

- A. 1-8
- B. 8-16
- C. 16-20

How many teeth perceived cavities?

- A. None
- B. 1-2
- C. 3-4
- D. 5-10
- E. 10-20

Noted presence of intraoral soft tissue pathology?

Yes No

If yes, circle all that apply:

- A. Ulcer
- B. Mucocele
- C. Inflamed Gingiva
- D. Herpes
- E. Lingual Frenum
- F. Abscess

Please circle all that apply:

- A. Early Tooth Eruption (<6 months)
- B. Poor Parental Dental Health
- C. Does the child go to bed with bottle/breast/cup?
- D. Frequent Snacking (3x or more per day)
- E. Enamel Defects/Pits
- F. Prolonged Bottle/Breast Feeding (>1 year)
- G. Well Water or non-fluoridated bottle water
- H. Greater than 3 weeks (continuous) of liquid meds
- I. None

ORAL HEALTH CARE QUESTIONS

Does someone clean the child's teeth daily?

Yes No

If yes, who? (circle one only)

- A. Parent
- B. Grandparent
- C. Sibling
- D. Guardian
- E. Not Reported

Does the child use toothpaste with fluoride?

Yes No

Does the child take fluoride supplements?

Yes If yes, Pills or Drops
No Not Reported

Does the child go to bed with bottle/breast/cup?

Yes No

If yes, circle all that apply:

- A. Water
- B. Milk
- C. Juice
- D. Soda/Soft Drink
- E. Sugar Water
- F. Other
- G. Not Reported

Does the child use a pacifier?

Yes No

If yes and dipped in anything, circle all that apply:

- A. Milk
- B. Juice
- C. Soda/Soft Drink
- D. Sugar Water
- E. Other
- F. Not Reported

Was fluoride varnish applied?

Yes No

Was education on oral health care provided?

Yes No

Including this visit, how many times have the screening, fluoride varnish and education been provided?

1 2 3
4 5 6

REFERRAL

Was dental referral for cavities/pathology made by physician?

Yes No

Was parent/guardian informed that dental referral is needed?

Yes No

If yes, who was the referral made to?

Dentist name: _____

Phone #: _____

Local health department: _____

Phone #: _____

Dental: _____

Phone #: _____

Provider Signature: _____