



Oral Health Advice Form

CHILD'S DETAILS		<input type="checkbox"/> SIBLINGS
Family Name:		First Name:
Address:		
Child's Medicare No:		Date of Birth:
Interpreter required: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which language:		
Aboriginal and/or Torres Strait Islander: <input type="checkbox"/> Yes <input type="checkbox"/> No		
PARENT/GUARDIAN DETAILS		
Name:		Relationship to child:
Mobile Phone No:		Hm/Wk Phone No:
<input type="checkbox"/> Referral to Public Sector <small>(I give consent for the Public Oral Health Services to use this information)</small>	<input type="checkbox"/> Parent chooses to go privately (I give consent for this Form to be forwarded to the Public Oral Health Services for de-identified Lift the Lip reporting purposes only)	
Signature:		Date:
ORAL HEALTH ASSESSMENT <i>(tick boxes)</i>	ACTION	
<input type="checkbox"/> Recent trauma or facial swelling	Immediate transfer to Dental Call Centre Fax: 4231 7009	
<input type="checkbox"/> White spot demineralisation		
<input type="checkbox"/> Cavitated lesions (holes)		
<input type="checkbox"/> Family requires oral health support		
<input type="checkbox"/> Frequent snacking (especially high sugar intake)	Discuss with parent and record findings Re-assess need for referral at next scheduled health check	
<input type="checkbox"/> Child takes a bottle to bed (or uses at will by day)		
<input type="checkbox"/> Special health needs / frequent medications		
<input type="checkbox"/> Visible plaque		
REFERRED BY (Health Professional)		
Name and Title:		
Location:		
Phone No:		Fax No:
Email:		
Postal Address:		
Additional information:		
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