Every Child Has a Toothbrush Program
FOLLOW-UP ASSESSMENT FORM

Patient: First Name ________________________Last __________________________ Date of Birth ___/___/___ Age ____ Sex: _____ (0 = male, 1 = female)

I. Screening (permanent) **D** = decay, **F** = filled, **M** = missing, **S** = Sealant present, **PS** = prescribe sealant, **RS** = recommend rese

No mark = no treatment recommended. *(Shaded areas most common permanent teeth for this age group).*

2	3	4	5	6	7	8	9	10	11	12	13	14	15
31	30	29	28	27	26	25	24	23	22	21	20	19	18

II. Screening (deciduous) **d** = decay, **f** = filled, **m** = missing, **No mark** = no treatment recommended.

(Shaded areas most common deciduous teeth for this age group).

A	B	C	D	E	F	G	H	I	J
T	S	R	Q	P	O	N	M	L	K

_______ / _______ = _________**DMF index Score**
D+M+F # Teeth

Mixed Dentition Score = _____ / _____ = _____ **Mixed Dentition Index Score x 100 =** ____%
DMF dmf

_______ / _______ = _________ **dmf index score**
d+m+f # teeth

D or d = Carious tooth, filled tooth with recurrent decay or new area of decay, temporary filling
M or m = Tooth missing due to decay **only**
F or f = Tooth has existing filling (no decay present – if decay is present it is counted as a D or d)

III. Preventive Services – Mark the teeth where sealants were placed with an **S.**

(Shaded areas most common sealable teeth for this age group).

2	3	4	5	12	13	14	15
31	30	29	28	21	20	19	18

Yes/No Oral Hygiene Instruction was given. If yes describe**:** ____

____

Yes/No Referral was recommended. If yes please describe: ____

____

Yes/ No Fluoride varnish treatment provided. If no explain why: ____

IV. Follow-Up – Mark teeth where sealants were retained with an **R**

2	3	4	5	12	13	14	15
31	30	29	28	21	20	19	18

Yes/No Referral was recommended. If yes describe: ____

____

Hygienist Name (*print*): ______________________ Signature: ______________________ Date: ____/____/____