



DOÑA ANA COUNTY HEAD START

Follow-Up To Dental Exam Form

Name of Child: _____

Center: _____

Date of Dental Exam: _____

Abnormal findings/diagnosis, noted during the Dental exam:

Is child taking any routine medications at this time? YES ____ NO ____

Was child referred to a specialist? YES ____ NO ____

If yes, name of specialist: _____

DATE OF FOLLOW-UP: _____

PROGNOSIS/Outcome: _____

Signature of Physician/Dentist/Specialist

Date

Please FAX to: Health Services Specialist
Doña Ana County Head Start
fax: (575) 647-8734
phone: (575) 647-8733 ext.123

ENTERED INTO CHILDPLUS

BY: _____

DATE: _____