ORAL PROTOCOL - FORM OP16

ORAL REFERRAL AND FOLLOW-UP

A1. ID LABEL HERE ---> |__| - |__|__| - |__|__|__|__| - |__|

A2.VISIT #: ___ ___

A3. VERSION DATE: **03/01/95c**

A4. FORM COMPLETED BY: ___ ___ ___

A5. DATE OF PROCEDURE ___ ___ / ___ ___ / ___ ___

B1. Does the participant have any treatment needs?

YES..... 1
NO ..... 2 **(B3)**

B2. Does participant require referral for any of the following reasons?

		YES	NO
a.	Preventive dentistry.....	1	2
b.	Restorations.....	1	2
c.	Crowns or fixed bridges.....	1	2
d.	Endodontics.....	1	2
e.	Periodontics.....	1	2
f.	Surgery	1	2
g.	Removable partial	1	2
h.	Complete denture	1	2
i	Biopsy	1	2
j	Other _____ **(SPECIFY)**	1	2

B3. TIME ORAL VISIT ENDED: |___|___| : |___|___|

AM 1
PM..... 2