

**WOMEN'S INTERAGENCY HIV STUDY
ORAL PROTOCOL: ORAL REFERRAL AND FOLLOW UP
FORM OP 16**

ID LABEL HERE ---> |_|-|_|-|_|_|_|-|_| VISIT#: _____ VERSION DATE
04/01/99

FORM COMPLETED BY: _____ DATE OF PROCEDURE: _____
 _____ / _____ / _____

1. Does the participant have any treatment needs?

YES 1
 NO 2

2. Does the 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. Oral Lesion / Lymph Node	1	2
j. Other: _____ <div style="text-align: center;">(SPECIFY)</div>		

3. NAME OF EXAMINER (**PLEASE PRINT!**): _____

4. TIME ORAL VISIT ENDED: |_|_| : |_|_| AM 1
 PM 2