

**Public Health Supervision Program
Summary Report Form**

I. Program Information and Demographics

A. Dates covered by this report: _____

B. General information

1. Program Name: _____

Address: _____

Phone: _____

2. Program services provided (check all that apply):

Oral screenings

Prophylaxis

Fluoride treatments

Individual oral hygiene education

Group dental health education

Sealants applied by program staff

Fluoride rinse programs

Referrals

Radiography

Operative

Endodontics

Surgery

Other: _____

3. Towns or counties served: _____

4. Population served (ie. school children, underserved adults, etc): _____

II. Program Services Provided

A. Total number of clients screened: _____

B. Number of clients receiving referral to a dentist: _____

Number of referrals to dentist for evaluation of caries _____

Divided by the

Number of clients screened _____ = Percent referred to dentist _____%

% Last year _____ % Previous year _____

C. Number of clients receiving preventive care (prophylaxis, OHI, fluoride treatments and/or sealants): _____

D. Number of clients participating in a fluoride rinse program: _____

E. Number of group (ie. classroom) dental health presentations: _____

III. Licensed Professional Staff and Support

A. Registered Dental Hygienists

- 1. Number of dental hygienists employed by this program: _____
- 2. Number of dental hygienists that volunteer with this program: _____
- 3. Please list names of dental hygienists associated with this program as employees or volunteers: (attach additional sheet if necessary) _____

B. Dentists

- 1. Number of Supervising Dentists for this program: _____
- 2. Number of dentists that volunteer with this program: _____
- 3. Please list names of dentists associated with this program as volunteers: (attach additional sheet if necessary) _____

Report Submitted by: _____

Date: _____

For Supervising Dentist(s):

I authorize the procedures carried out by the dental hygienists associated with this program and review the dental records of clients served by this public health dental program once in a twelve month period.

Date: _____

Signature: _____

Printed Name of Supervising Dentist: _____

Address: _____

Phone: _____

Date: _____

Signature: _____

Printed Name of Supervising Dentist: _____

Address: _____

Phone: _____