Keep your Smile

Program Consent

TO REGISTER THE CHILD, PLEASE COMPLETE THIS FORM AND RETURN BY: / /		
Child's given name:	Child's family name:	
Date of Birth: / /	Sex: ☐ M ☐ F ☐ I	
Address:	Postcode:	
Email:	Phone:	
School / Campus / Facility:	Class / Group:	
Medicare Number:	Ref No.: Valid to: /	
Is the child of Aboriginal or Torres Strait Islander Origin? Your accurate response to the Indigenous status question assists QLD Health in delivering the best possible health care to all patients ☐ No ☐ Aboriginal ☐ Torres Strait Islander ☐ both Aboriginal & Torres Strait Islander		
Is the child of Australian South Sea Islander ancestry?	☐ Yes ☐ No ☐ Unknown	

HAVE THEY EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?	Yes	No
Asthma:		
Other condition/s: If **YES**, please give details:		
Is the child taking any tablets or medicines? If **YES**, please give details:		
Has the child had fluoride varnish professionally applied to their teeth previously? If **YES**, please give details: Date of application: / /		
Please list any known allergies the child has e.g. mild protein, colophony / rosin:		

I, the Parent / Carer / Legal Guardian of the child named above give my consent for their participation in the Keep Your Smile Program. Parent / Carer / Legal Guardian's Name: _____ Signature: _____ Date: _____/_____/_____	**Office Use Only** Checked by Dental Practitioner _____

OFFICE USE ONLY

3C's VERIFICATION CHECKLIST

Step 1 ☐ IDENTIFY PATIENT Step 2 ☐ INFORMED CONSENT Step 3 ☐ PROCEDURE TO BE PERFORMED Step 4 ☐ FINAL TEAM CHECK	Print Name: _____ Signature: _____ Date: _____/_____/_____

CLINICAL FINDINGS		YES - Details
⚠ Pain / Infection / Swelling	☐ Yes ☐ No	
⚠ White spots or visible decalcifications	☐ Yes ☐ No	
⚠ Obvious decay	☐ Yes ☐ No	
⚠ Restorations present	☐ Yes ☐ No	
Visible plaque accumulation	☐ Yes ☐ No	
Calculus	☐ Yes ☐ No	
Gingivitis	☐ Yes ☐ No	
Other:		
Carries Risk: ☐ High ☐ Low		

TREATMENT / PROCEDURES PERFORMED

Code	Description	Provided	Clinician
013	Oral examination - limited		
141	Oral hygiene instruction		
121	Topical application of remineralization agents - one treatment		

Recommended Care: ☐ Urgent Care ☐ General Care ☐ Preventative Care

Office Use Only

☐ Activity Based Funding processed

☐ ISOH processed

☐ Urgent Care Clients contacted by phone to schedule comprehensive examination

☐ General Care Clients contacted by phone to discuss concerns and schedule appointment as required

☐ Preventative Care Clients placed on appropriate Recall CAOHS list when eligible