HS0064
Rev. 12/18

DENTAL REFERRAL LETTER

Health Services Department
Lincoln Public Schools

Date: _____

To the Parent/Guardian of: _____

DOB: _____

In accordance with Nebraska School Law, your child has received a limited dental screening at school. This dental screening does not take the place of a regular examination by a private dentist, but it may help find an obvious dental problem and bring it to your attention.

Date of Screening: _____

- ❑ The person named above has no obvious dental problems but should continue to have routine examinations by your family dentist. **Category 0**
- ❑ The person named above has tooth or teeth that should be evaluated by your family dentist and may need early dental care before your next regular dental appointment. You should contact your dentist to schedule an appointment to determine whether any treatment is needed. **Category 1**
- ❑ The person named above has a tooth or teeth that appear to need immediate care. Contact your family dentist as soon as possible for an urgent dental evaluation. **Category 2**
- ❑ The results of your child's school dental inspection include a recommendation for orthodontic exam. Orthodontic referrals are recommended when the teeth are crowded, crooked, and out of alignment with each other. This can occur at any age, but becomes particularly noticeable between the ages of 6 and 12, when the permanent teeth are coming in. Teeth that are crowded or out of position may be more difficult to clean and are more likely to decay or develop gum disease.

Screener Comments:

If you do not have a family dentist and you need help obtaining dental care you may contact:
www.nedental.org/oralhealth/find a dentist.html Nebraska Dental Association 402-476-1704
www.insurekidsnow.gov use "find a dentist for your kid tool for Medicaid dentists
www.dhhs.ne.gov/dental look for link listing NE Public Health Dental Clinics
Lincoln Lancaster Dental Clinic 3140 N St, 402-441-8015

Please have your dental examiner complete the Report of Dental Examination on the reverse side of this letter, then return it to the school health office.

Thank you for your assistance,

_____

School Nurse *School* *Phone Number*

EXAMINER'S REPORT

Health Services Department

Lincoln Public Schools

Student Name: _____

Student DOB: _____

This is to certify that I have thoroughly examined the teeth of the student above.

- ❑ All necessary dental work has been completed.
- ❑ No dental work is necessary at this time.
- ❑ Treatment is scheduled.
- ❑ Further recommendations: _____

Date: _____ Signature of Dentist: _____

Printed name & address of dentist:

_____

_____

_____

PLEASE PROVIDE THIS FORM TO THE FAMILY SO THEY MAY RETURN IT TO THE SCHOOL HEALTH OFFICE.