

Kern County  
Children's



## Dental Treatment Referral

Date: \_\_\_\_\_

Child's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

School: \_\_\_\_\_

Phone #: \_\_\_\_\_

Parent Name: \_\_\_\_\_

Address: \_\_\_\_\_

Insurance #: \_\_\_\_\_

Referring Nurse & Phone #: \_\_\_\_\_

School District: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Attn: Barbara Antongiovanni**

**Fax #: 661-377-0329**

**KERN COUNTY CHILDREN'S DENTAL HEALTH NETWORK  
Screening Form**

SCHOOL: \_\_\_\_\_

SCREENING DATE: \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

**IDENTIFYING INFORMATION**

Parent/Guardian Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

Phone Number \_\_\_\_\_

Last Name First Name Date of Birth Social Security # Teacher Name/Grade
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**TREATMENT URGENCY  
(√ answer)**

√	CLASS	DEFINITION	REFERRAL
	Class I	No dental caries or other pathology visible	None
	Class II	Visible caries present on 8 teeth or less	Yes
	Class III	Definite caries present on 8 or more teeth w/possible pulpal involvement	Yes
	Class IV	Child in pain or infection is present.	Yes- immed.