

Instruction Sheet for New Dental Formats (Revised in 2023)

1. Instructions for completing the Monthly Return - School Dental Clinics (H 982):

Regarding 1.4 - Children with Caries in Primary Molars:

- We consider this parameter only in children who have received the Fluoride Varnish application. Please include **Caries Experience** in both "D" and "E" of primary dentition when the child is in Grade one (active caries, restorations, and missing due to extraction). Please check the Fluoride Varnish Application Card to cross-check whether the child had dental caries in D and E prior to Fluoride Varnish application.

Regarding 1.6 - Children identified as High Risk in Grade 1

- Please use the criteria in the guideline to determine a grade one child as "high risk" for caries in the Fissure Sealant programme.

Regarding 5.3- Children Identified as High Risk under the Preschool

- Consider the criteria provided in the guideline for Fluoride Varnish application to identify preschool children as high-risk children.

Regarding 5.4- Children Received Fluoride Varnish 1st time

- Mention the number of preschool children who received Fluoride Varnish 1st time.

Regarding 5.5- Children Received Fluoride Varnish 2nd time

- Mention the number of preschool children who received Fluoride Varnish 2nd time.

Special Note: As there are no cells to report the children received fluoride varnish 1st time and 2nd time for the Grade 1 group please mention it under space 5.6 on the first page. The necessary revisions will be done in the formats that will be printed in 2024.

Grade 1 children received fluoride varnish 1st time (mention the number)

Grade 1 children received fluoride varnish 2nd time (mention the number)

Regarding 9.2 - Fissure sealants (no. of children)

- This should include children who received Fissure Sealants from Grades 1 and 2 in the particular month (out of high risk).

Regarding 10.2 and 10.3 – Restorations in old format 2011

- The term "Amalgam" has been removed in the new format (2023). Please update accordingly.

Regarding 13 -Referrals

- School children needing specialized oral health care should be referred to the nearest government OPD dental clinic, adolescent dental clinic, or community dental clinic first. With the recommendation of a dental surgeon, the child should be referred to the specialized oral health unit.

Regarding 15.1 & 15.2 Oral Health Education -Target group

- Consider the target group as mentioned in the School Dental Service national target.
 - Group- less than 50 individuals participated. (Individual chair-side education sessions should not be included).
 - Mass – more than 50 Individuals participated

Regarding 15.3 & 15.4 - Oral Health Education- Non target group

Please consider the following groups as non-target groups.

- School staff
- Pre-school staff
- Parents
- Pregnant mothers
- Any other particular group

2. Instructions for Completing Examination and History Charts (H 975)

Please note the following updates and additions while filling out the charts:

- 1) A new “Preschool Examination” segment has been integrated into the existing Examination boxes. Kindly complete this section using the same index.
- 2) An additional section has been incorporated as follows:

White Chalky Appearance in Anterior or Posterior Deciduous Teeth: Indicate whether a white chalky appearance is present or absent in the anterior or posterior deciduous teeth.
- 3) The box previously labelled as “condition of gums” has now been changed to “Oral Hygiene Status using Plaque Score/Index.”

4) A new section, "Fluoride Application," has been included. The following three sections were adopted under the fluoride varnish application.

- I. Date of 1st Fluoride Application.
- II. Date of 2nd Fluoride Application.
- III. Findings after the one year of 2nd application (after completing the fluoride varnish therapy)

The success of the fluoride varnish programme provided for preschool children will be evaluated by caries experience in the primary molar teeth (D and E) of children screened at grade 1.

When you start the fluoride varnish application, you have to issue a Fluoride Varnish Application card to the parent of that particular child. The sample format is provided with the instruction sheet. You have to mention whether the child had molar caries (D and E) on that card at the first screening.

3. Instructions for completing the Daily Record of Treatments (H 974):

1. **Care Provided Column:** The term "Amalgam" has been removed. Please update accordingly.
2. **Examination Field:** A new column named "White Spots in Anterior/Posterior Dec" has been added. Fill this column based on the Examination and History Chart.
3. **Fluoride Application Column:** This has been divided into "1st Fluoride Application" and "2nd Fluoride Application." Complete these columns based on the Examination and History Chart.



FLUORIDE VARNISH APPLICATION CARD
FOR CHILDREN SIX YEARS AND BELOW
NATIONAL FLUORIDE VARNISH APPLICATION PROGRAMME

NameRegistration No.....

Date of Birth.....Age.....

Home Address.....

.....Tele. No.....

District.....MOH.....

Consent received on (Date).....

Name of the parent/guardian

Details Of Fluoride Application

Date of screening		
Findings at the screening	Yes	No
Caries present in primary molars (D+E or D/E)		
If yes, specify the primary molar teeth with dental caries: (Mention the caries experience d/m/f)	_____	_____
Date of 1 st application		
Date of 2 nd application		
*Findings after completion of Fluoride varnish therapy	Yes	No
New caries present in primary molars (D+E or D/E)		
*If yes, specify the primary molar teeth with dental caries: (Mention the caries experience d/m/f)	_____	_____

*Please complete these two rows, when the child is screened in Grade 1

School Dental Service

Daily Record of Treatments

Guide to fill Daily Record of Treatments

General information

- When a patient visits the SDC or when a SDT visits a school to screen children, all names should be entered in daily record of treatment book.
- It is preferable to use different coloured pens for different groups.
- Always maintain two daily record books if SDTT carry out group-mobiles to cover target groups. One book for routine entries (base & out-reach work) and the other for visiting SDTT (who helps to complete the target).

Other defects: Followings can be marked under this column.

Example: Mucocele High frenal attachment Fractured teeth and any other oral defect that was not classified under the previous headings

Referral- Ortho/ other: Reason for referral should be marked.

E.g.: If it is for an orthodontic reason: 'Ortho'

If it is a fractured Central Incisor: # 1

Other treatments: Any other treatment provided that could not be categorized under the above headings could be inserted here.

Examples; 1. Extractions 2. Partial scaling 3. Cleaning & polishing of teeth 4. Stain removal

Malocclusion: Criteria for referrals for Malocclusion:

Aim is to identify severe malocclusions in the upper anterior segment. If one or more of these present, refer for orthodontic treatment.

If a child is not belonging to these categories, but parent is insisting, advice to go to the nearest hospital clinic for further screening for treatment

- | | |
|---|--|
| <ul style="list-style-type: none"> ○ Cleft lip/palate ○ Permanent tooth/teeth erupted completely out of the arch ○ Anterior cross bite ○ Reverse over-jet (Class III malocclusion) ○ Congenitally missing permanent anterior teeth ○ Over-jet more than 8mm (more then 1/3 of a diameter of a mouth mirror) | <ul style="list-style-type: none"> ○ Deep Over-bite: covers more than 2/3 of lower teeth ○ Upper Arch Crowding – more than 5mm (overlapping areas of teeth are more than the width of upper central incisor) ○ Upper Arch Spacing – more than 5 mm (spaces more than the width of uppercentral incisor) |
|---|--|

Treatment completion: only 6 possible entries

C = Casual patient

H = Healthy; *(child do not have dental caries or gum disease. i.e. gingivitis or calculus. Do not consider 'Malocclusion' or 'Dental Fluorosis' or 'Other defects' to classify children into this category)*

Appt = Appointment given *(child need further treatments, not completed)*

RC = Restorations completed (for Grade 7 children, consider only permanent teeth)

SC = Scaling completed

TC = Treatment completed *(all treatment needs completed)*

Abbreviations: Dec. = Deciduous Per. = Permanent

Treatments				1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	Total				
6	Casual Patients Treated																																						
7	Children with Dental Fluorosis																																						
8	Children with Malocclusion																																						
9.1	Fissure Sealants (no. of teeth)																																						
9.2	Fissure Sealants (no. of children)																																						
10.1	Restorations	Temporary																																					
10.2		GIC	Deciduous Teeth																																				
10.3			Permanent Teeth																																				
11	Full Mouth Scaling																																						
12	Other Treatments																																						
13	Referrals																																						
14.1	Number of Children Seen in the Clinic																																						
14.2	Number of Children Seen in the Field																																						
14.3	Total no of Children Seen																																						
15.1	Oral Health Education	Target	Group																																				
15.2			Mass																																				
15.3		Non-target	Group																																				
15.4			Mass																																				
16.1	Supervisory Visits	RDS																																					
16.2		SSDT																																					
16.3		MOH																																					
16.4		Other																																					

Comments:

No. of outreach clinics attended: Target group:
 Outside target:

Allocated schools screened
 Allocated schools completed

No. of days worked:
 No. of days on leave:

Prepared by: _____

Certified by: _____

Date: _____

Date: _____

Note: The monthly return should be prepared by all School Dental Therapists and certified by MOH. It should be prepared in triplicate, the first copy should be sent to RDHS Office, second to the MOH, and the third filed in the clinic.

