UNIVERSITY OF THE FRASER VALLEY

UFV DENTAL TREATMENT SCREENING FORM

This form must be completed and signed by a licensed dentist before treatment can be rendered.

TO THE DENTIST:

Our dental assisting students are providing dental services for clients as part of their clinical course. Please examine this client and indicate on this form, which services our students may perform.

Please note:

- **Clients eligible for radiographs are those with either a mixed or permanent dentition**
- ***Client must obtain authorization in compliance with the 60 Day rule.***
- **The client must be calculus free before attending our clinic for coronal polishing**

The UFV Dental Clinic practices in accordance with ALARA radiographic principles.

Client's Name: _____ is eligible to receive the following services:

PLEASE CHECK APPROPRIATE AREAS (✓) and provide additional information where necessary**.**

✓	**UFV SERVICES AVAILABLE** **to be completed by dentist**
	Radiographs
___	• Periapicals Specify teeth#: _____
___	• 4 BW's
___	• 2 BW's
___	**Coronal Polishing** Client is calculus free. _____ Was scaled on _____
___	**Topical Fluoride/Varnish**
___	**Fissure Sealants** Must specify individual teeth #: _____

**** Treatment must be rendered within 60 days of authorization.***

**** Any radiographs that are taken, will be forwarded via an encrypted email service, to dentist's email address provided below.***

I confirm that I have reviewed this client's medical history and that there are no contraindications, either medical or dental, for the above procedures which I have prescribed.

Dentist's Signature: _____ Date: _____

Dentist's Name: _____ Telephone: _____

Dentist's Address: _____

Dentist's Email Address: _____