CARIES RISK ASSESSMENT FORM FOR AGES 0 TO 5 YRS OLD

Patient Name:_____ I.D.#_____ Age:_____

Date:_____ Assessment Date: _____

NOTE: Any one YES in Column 1 signifies likely "High Risk" and an indication for bacteria tests	YES = CIRCLE 1	2	3	Comments:
1. Risk Factors (Biological Predisposing Factors)				
(a) Mother/caregiver has active dental decay in past year	YES			
(b) Bottle with fluid other than water, plain milk and/or formula		YES		Type(s):
(c) Continual bottle use		YES		
(d) Child sleeps with a bottle, or nurses on demand		YES		
(e) Frequent **(> 3 times/day)** between-meal snacks of sugars/cooked starch/sugared beverages		YES		# times/day: Type(s):
(f) Saliva-Reducing factors are present, including: 1. medications (e.g., asthma [albuterol] or hyperactivity) 2. medical (cancer treatment) or genetic factors		YES		
(g) Child has Special Health Care Needs		YES		
(h) Parent and/or caregiver has low SES (Socio-economic status) and/or low health literacy, WIC/Early Head Start		YES		
2. Protective Factors				
(a) Child lives in a fluoridated community (note zip code)			YES	Zip Code:
(b) Takes fluoride supplements			YES	
(c) Child drinks fluoridated water (e.g., tap water)			YES	
(d) Teeth brushed with fluoride toothpaste (pea size) at least 2x daily			YES	# times/day:
(e) Fluoride varnish in last 6 months			YES	
(f) Mother/caregiver understands use of xylitol gum/lozenges			YES	
(g) Child is given xylitol (recommended wipes, spray, gel)			YES	
3. Disease Indicators - Clinical Examination of Child				
(a) Obvious white spots, decalcifications, or decay present on the child's teeth	YES			
(b) Existing restorations	YES			
(c) Plaque is obvious on the teeth and/or gums bleed easily		YES		
(d) Visually inadequate saliva flow		YES		
(e) New remineralization since last visit (List teeth):			YES	Teeth:

Child's Overall Caries Risk (circle): HIGH MODERATE LOW

Child: Bacteria/Saliva Test Results:	MS:	LB:	Flow Rate:	ml/min:	Date:
Caregiver: Bacteria/Saliva Test Results:	MS:	LB:	Flow Rate:	ml/min:	Date:

Self-management goals:

1. _____

2. _____

Since Last Visit:

New Cavitation: Y / N

New White Spot Lesions: Y / N

Dental Pain: Y / N

Referral Needed on: _____

Clinician's Signature: _____ Date: _____

(Updated: 5/1/14)