DENTAL TREATMENT PLAN

For use of this form, see TB MED 250; proponent agency is Office of TSG.

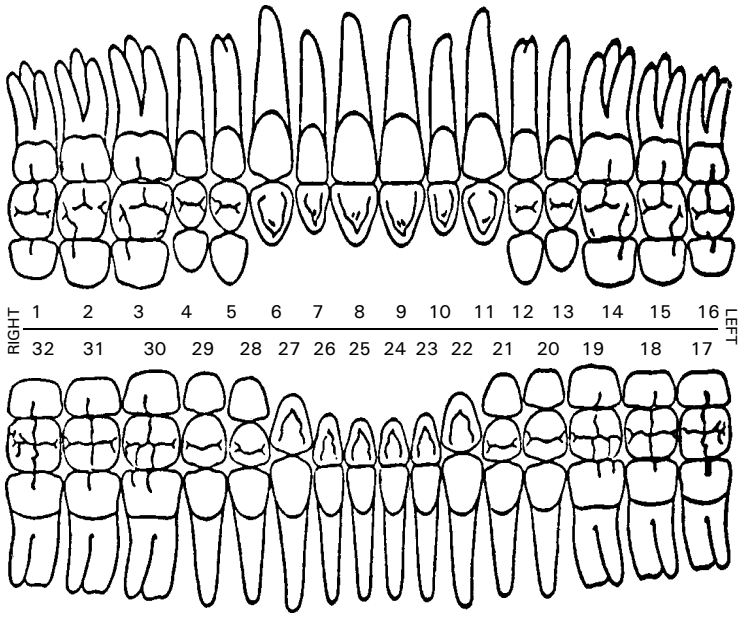
1. **CONSULTATION DESIRED** ☐ **YES** ☐ **NO**
(If yes, complete Section III, on reverse side)

SECTION I - PLANNED TREATMENT AND SEQUENCE OF ACCOMPLISHMENT

Check items in Column c to indicate treatment planned. If sequence of treatment is other than that printed in column b, use numbers (1 thru 10) in column c to show desired order.

LINE	CODE a	TYPE TREATMENT b	PLANNED SE-QUENCE c	ACCOM-PLISHED d
2	**A**	URGENT		
3	**B**	PERIODONTAL		
4	**C**	PROPHYLAXIS ☐ **SnF2** PASTE		
5	**D**	TOPICAL **SnF2** REPEAT AFTER_____MONTHS		
6	**E**	COUNSELING IN SELF CARE		
7	**F**	OCCLUSION		
8	**G**	SURGERY		
9	**H**	RESTORATIONS		
10	**I**	PROSTHESES		
11	**J**	OTHER *(specify)*		

CHART
Chart ONLY missing teeth and TREATMENT TO BE ACCOMPLISHED.
Do NOT chart existing Pathology or Restorations.
e



12. REMARKS OR INSTRUCTIONS
Use this space for additional clarification of recommended treatment or for describing treatment which does not lend itself to charting. Indicate nature of treatment and teeth or other tissues involved. Identify entry by code letter (Column a, above).

13. DATE	14. TREATMENT FACILITY	15. SIGNATURE OF DENTIST RECORDING TREATMENT PLAN

SECTION II - PATIENT IDENTIFICATION

16. SEX	17. RACE	18. GRADE	19. ORGANIZATION

20. PATIENT'S LAST NAME - FIRST NAME - MIDDLE INITIAL	21. DATE OF BIRTH	22. IDENTIFICATION NUMBER

SECTION III - CONSULTATION REQUEST *(To be completed by requesting officer)*			
CONSULTATION DESIRED *(Indicate by check mark(s))*			REMARKS *(If appropriate)*
23		PROSTHODONTIC	
24		PERIODONTIC	
25		ORAL SURGERY	
26		OPERATIVE	
27		CROWN AND BRIDGE	
28		OTHER *(specify)*	

29. **SECTION IV - CONSULTANT REMARKS AND RECOMMENDATIONS**
(Initial after each entry and identify entry by number)