

Domestic Violence Dental Care Program Evaluation Report[©]

Date: _____

Doctor Name: _____

Telephone Number: _____

Patient CODE: _____

Problems noted:

Treatment Needed (or attach tx est.):

1. _____
2. _____
3. _____
4. _____

Estimated Value of Service:

- \$ _____
- \$ _____
- \$ _____
- \$ _____
- \$ _____

Total dollar value of treatment is estimated to be:

\$ _____

Dental laboratory cost is estimated to be: \$ _____

Preferred lab(s) of choice: 1. _____ 2. _____ 3. _____

Anticipated treatment length or approx. # of office visits required: _____

- I have received a copy of the patient's permission/release to disclose this information to MDDS
- I have advised patient of services, which may or may not be, offered by this office through my participation in this program. (Services are provided at YOUR complete discretion).

Please check one:

- I would like to proceed with and provide comprehensive treatment.
- I choose to proceed with partial treatment, including:

- Patient requires or seeks services outside the scope of my participation in this program, including: (please indicate the order in which specialist appts. should be scheduled)
____ Oral Surgery ____ Endo ____ Perio ____ Ortho ____ Prosthodontics ____ Pediatrics
 - Please arrange a specialist evaluation with participating program volunteer(s).
 - I recommend _____ (doctor's name). Please contact him/her to discuss interest in participating in this case only.
 - I have already recruited _____ (doctor's name) to work with me on this case. Please contact his/her office with appropriate documents for participation.
- I choose not to proceed with any further treatment at this time.
- Patient does not meet program criteria.

REMARKS:

____ **Yes, I would be willing to evaluate a future patient through the MDDF Domestic Violence Dental Care Program.**

Please return
By Fax:
(303) 488-0177
By Mail:
Attn: CONFIDENTIAL/DVDCP
Metro Denver Dental Foundation
3690 South Yosemite Street, #200
Denver, CO 80237