



<b>DENTAL TREATMENT PLAN</b> <small>For use of this form, see TB MED 250; proponent agency is Office of TSG.</small>					<b>1. CONSULTATION DESIRED</b> <input type="checkbox"/> YES <input type="checkbox"/> NO <small>(If yes, complete Section III, on reverse side)</small>	
<b>SECTION I - PLANNED TREATMENT AND SEQUENCE OF ACCOMPLISHMENT</b> <i>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.</i>						
LINE	CODE	TYPE TREATMENT <small>b</small>	PLANNED SE- QUENCE <small>c</small>	ACCOM- PLISHED <small>d</small>	<b>CHART</b> <small>Chart ONLY missing teeth and TREATMENT TO BE ACCOMPLISHED. Do NOT chart existing Pathology or Restorations. <small>e</small></small>	
2	A	URGENT				
3	B	PERIODONTAL				
4	C	PROPHYLAXIS <input type="checkbox"/> SnF2 PASTE				
5	D	TOPICAL SnF2 REPEAT AFTER _____ MONTHS				
6	E	COUNSELING IN SELF CARE				
7	F	OCCCLUSION				
8	G	SURGERY				
9	H	RESTORATIONS				
10	I	PROSTHESES				
11	J	OTHER (specify)				
<b>12. REMARKS OR INSTRUCTIONS</b> <small>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).</small>						
13. DATE		14. TREATMENT FACILITY			15. SIGNATURE OF DENTIST RECORDING TREATMENT PLAN	
<b>SECTION II - PATIENT IDENTIFICATION</b>						
16. SEX	17. RACE	18. GRADE	19. ORGANIZATION			
20. PATIENT'S LAST NAME - FIRST NAME - MIDDLE INITIAL					21. DATE OF BIRTH	22. IDENTIFICATION NUMBER

[illegible]