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| **Completed by (initials)** |

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| **Visit type (Tick one option)** | Month 0 ☐Month 1 ☐ Month 2 ☐ Month 3 ☐ Month 6 ☐ **Supplementary visit** ☐ |
| **Completed by (role) (Tick one option)** | DT ☐ DN ☐ Both ☐ |
| **Date of intervention** |

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| **Start time (hh:mm – 24 hr)** |

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| **Detail of intervention (Tick all that apply)** | **DTs** ☐ Examination☐ Scaling☐ Direct restorations☐ Fluoride varnish☐ Toothbrush instruction☐ Diet advice☐ Denture cleaning☐ Denture advice☐ Other activities If yes, detail:**DNs:**☐ Fluoride varnish☐ Toothbrush instruction☐ Diet advice☐ Denture cleaning☐ Denture advice☐ Other activities. If yes, detail: |
| **End time (hh:mm – 24 hr)** |

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