|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Completed by (initials)** | |  |  |  | | --- | --- | --- | |  |  |  | |
| **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** | |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | / |  |  | / |  |  |  |  | |
| **Start time (hh:mm – 24 hr)** | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  | **:** |  |  | |
| **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)** | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  |  | **:** |  |  | |