Dental Care (DN) Section

DN01
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OMITTED.

DN02
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OMITTED.

DN03
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{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE
PROVIDER......} {EVN-DT}

What type of dental care provider did (PERSON) see during this
visit?

PROBE: Any other type of dental care person?

CHECK ALL THAT APPLY.

GENERAL DENTIST .... 1 {DN04}
DENTAL HYGIENIST .... 2 {DN04}
DENTAL TECHNICIAN .... 3 {DN04}
DENTAL SURGEON .... 4 {DN04}
ORTHODONTIST .... 5 {DN04}
ENDODONTIST .... 6 {DN04}
PERIODONTIST .... 7 {DN04}
OTHER .... 91 {DN04}
REF .... -7 {DN04}
DK .... -8 {DN04}

[Code All That Apply]

HELP AVAILABLE FOR DEFINITIONS OF ANSWER CATEGORIES.

| FOR SPECIFICATIONS PURPOSES ONLY (CAPI HANDLES |
| AUTOMATICALLY): CAPI DOES NOT ALLOW -7 OR -8 IN |
| COMBINATION WITH ANY OTHER CODE. |

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DN04
====

{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE PROVIDER......} {EVN-DT}

SHOW CARD DN-1.

What did (PERSON) have done during this visit?
PROBE: What else was done?

CHECK ALL THAT APPLY.

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  *DIAGNOSTIC OR PREVENTATIVE
     GENERAL EXAM, CHECKUP OR CONSULTATION ..  1
     CLEANING, PROPHYLAXIS, OR POLISHING ....  2
     X-RAYS, RADIOGRAPHS, OR BITEWINGS ......  3
     FLUORIDE TREATMENT .....................  4
     SEALANT (PLASTIC COATINGS ON BACK
     TEETH) .................................  5
  *RESTORATIVE OR ENDODONTIC
     FILLINGS ...............................  6
     INLAYS .................................  7
     CROWNS OR CAPS .........................  8
     ROOT CANAL .............................  9
  *PERIODONTIC (GUM TREATMENT)
     PERIODONTAL SCALING, ROOT PLANING, OR
     GUM SURGERY ............................ 10
     PERIODONTAL RECALL VISIT (PERIODIC OR
     REGULAR) ............................... 11
  *ORAL SURGERY
     EXTRACTION, TOOTH PULLED ............... 12
     IMPLANTS ............................... 13
     ABSCESS OR INFECTION TREATMENT ........ 14
     OTHER ORAL SURGERY .................... 15
  *PROSTHETICS
     FIXED BRIDGES ......................... 16
     DENTURES OR REMOVABLE PARTIAL DENTURES . 17
     RELINING OR REPAIR OF BRIDGES OR
     DENTURES .............................. 18
  *ORTHODONTICS
     ORTHODONTIA, BRACES, OR RETAINERS ...... 19
  *ADDITIONAL PROCEDURES
     BOND, WHITEN, OR BLEACH ................ 20
     TREATMENT FOR TMD OR TMJ ............... 21
     OTHER ................................. 91 {DN04OV}
     REF ................................... -7
     DK .................................... -8
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[Code All That Apply]

HELP AVAILABLE FOR DEFINITIONS OF ANSWER CATEGORIES.

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| HEADINGS AND CODE CATEGORIES WILL NOT FIT ON ONE    |
| SCREEN.  THEREFORE, HEADINGS WILL ONLY APPEAR ON    |
| HELP SCREEN AND SHOW CARD DN-1.  HEADINGS SHOULD    |
| BE ASSOCIATED WITH CODES AS FOLLOWS:                |
| *DIAGNOSTIC OR PREVENTATIVE = CODES 1-5             |
| *RESTORATIVE OR ENDODONTIC = CODES 6-9              |
| *PERIODONTIC (GUM TREATMENT) = CODES 10-11          |
| *ORAL SURGERY = CODES 12-15                         |
| *PROSTHETICS = CODES 16-18                          |
| *ORTHODONTICS = CODE 19                             |
| *ADDITIONAL PROCEDURES = CODES 20-21 AND 91         |
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| FOR SPECIFICATIONS PURPOSES ONLY (CAPI HANDLES      |
| AUTOMATICALLY): CAPI DOES NOT ALLOW -7 OR -8 IN     |
| COMBINATION WITH ANY OTHER CODE.                    |
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| IF CODE '91' (OTHER) ENTERED ALONE OR IN            |
| COMBINATION WITH ANY OTHER CODE, CONTINUE WITH      |
| DN04OV                                              |
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| OTHERWISE, GO TO DN05                               |
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DN04OV
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        OTHER TYPE OF DENTAL CARE:

            [Enter Other Specify]...................   {DN05}
            REF .... -7 {DN05}
            DK .... -8 {DN05}

DN05
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{PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE
PROVIDER......} {EVN-DT}

During this visit, were any medicines prescribed for
(PERSON)? Please include only prescriptions which were
filled.

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YES ..................................... 1 {DN06}
NO ...................................... 2 {BOX_01}
REF ..................................... -7 {BOX_01}
DK ...................................... -8 {BOX_01}
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HELP AVAILABLE FOR DEFINITION OF PRESCRIBED MEDICINE.

DN06
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            {PERSON'S FIRST MIDDLE AND LAST NAME} {NAME OF MEDICAL CARE
            PROVIDER......} {EVN-DT}

            Please tell me the names of the prescriptions from this
            visit that were filled.

            PROBE: Any other prescriptions from this visit filled?

                [1. Prescribed Medicine]
                [2. Prescribed Medicine]
                [3. Prescribed Medicine]

            | ROSTER DETAILS: |
            | TITLE: PERSON'S-PRESCRIBED-MEDICINES_1. |
            | |
            | COL # 1 HEADER: PRESCRIBED MEDICINE |
            | INSTRUCTIONS: DISPLAY PMED NAME (PMED.PMEDNAME) |

            | ROSTER DEFINITION: |
            | THIS ITEM DISPLAYS PERSON'S-PRESCRIBED-MEDICINES- |
            | ROSTER FOR SELECTION AND ADDITION OF PRESCRIBED |
            | MEDICINES. |

            | ROSTER BEHAVIOR: |
            | 1. MULTIPLE SELECT AND ADD ALLOWED. |
            | |
            | 2. LIMITED DELETE ALLOWED. INTERVIEWER MAY DELETE |
            | A PMED ADDED ON THIS SCREEN AS LONG AS CAPI HAS |
            | NOT YET CREATED THE LINK BETWEEN THIS PMED AND THE|
            | EVENT. |
            | |
            | 3. EDIT DISALLOWED. |

            | ROSTER FILTER: |
            | NONE, DISPLAY ALL. |

BOX_01
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|  IF THE CHARGE/PAYMENT MODULE HAS NOT BEEN ASKED   |
|  FOR THE EVENT-PROVIDER PAIR BEING ASKED ABOUT, GO |
|  TO THE CHARGE/PAYMENT (CP) SECTION.               |
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|  OTHERWISE, GO TO THE EVENT DRIVER (ED) SECTION.   |
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