



Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

October 16, 2018

DEPARTMENT MEMORANDUM

No. 2018 - 0369

FOR : **REGIONAL SECRETARY OF DOH-ARMM, ALL CENTERS FOR HEALTH DEVELOPMENT DIRECTORS, REGIONAL ORAL HEALTH COORDINATORS AND OTHERS CONCERNED**

SUBJECT: **Use of Revised Oral Health Forms 1 (Individual Patient Treatment Record) and 2 (Consolidated Oral Health Status, Services and Medical History Report)**

With reference to the abovementioned subject, DOH-ARMM, all Centers for Health Development, Provincial Health Offices (PHOs), City Health Offices (CHOs), and Municipal Health Offices (MHOs) are hereby informed regarding the use of revised oral health forms 1 and 2 as the official National Oral Health Program (NOHP) standard reporting forms for assessing the medical history and oral health status of the patients including the oral health services they have received.

The following guidelines are to be followed:

1. All oral health services in all levels of health delivery namely: rural, hospital, sanitaria, provincial, city, municipal, puericulture center under DOH or Local Government Units are required to record findings of yearly oral examinations and oral health services rendered to each patient in the oral health form 1 (OHF1) also known as the Individual Patient Treatment Record. (Please see Annex for reference).
2. All operating dental units are required to accomplish and submit a monthly report on a quarterly basis, quarterly and annual consolidated report of oral diseases and services using the oral health form 2 (OHF2) also known as the Consolidated Oral Health Status, Services and Medical History Report. (Please see Annex for reference).
3. **Health Centers and Hospitals** – each Public Health Dentist shall accomplish OHF2 in four (4) copies; one copy for his/her file, one copy for the facility, two copies to be submitted to the Provincial/City Health Officer every third week of the first month of the succeeding quarter.
4. **Provincial/City** – the Provincial Health Officer through the Provincial Oral Health Coordinator shall consolidate health facility report in four (4) copies; one copy for his/her file, one copy for the facility, two copies to be submitted to the DOH-ROs or DOH-ARMM every 4th week of the 1st month of the succeeding quarter.
5. **Region** – The Regional Secretary of DOH-ARMM or the Center for Health Development Director through the Regional Oral Health Coordinator shall consolidate provincial/city reports in four (4) copies; one copy for his/her file,

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Date January 21, 2019

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one copy for the DOH-RO or DOH-ARMM and two copies to be submitted to the Disease Prevention and Control Bureau (DPCB), Department of Health – Central Office (DOH-CO) every 2nd week of the 2nd month of the succeeding quarter.

This Department Memorandum hereby directs all recipients to strictly adhere to the abovementioned guidelines and shall take effect immediately.

By Authority of the Secretary of Health:


MYRNA C. CABOTAJE, MD, MPH, CESO III
OIC-Undersecretary of Health
Public Health Services Team

Malignancy (Please specify) _____
 History of Previous Hospitalization:
 Medical (Last Admission & Cause) _____
 Surgical (Post-Operative) _____
 Blood transfusion (Month & Year) _____
 Tattoo _____
 Others (Please specify) _____

Dietary Habits / Social History

Sugar Sweetened Beverages/Food (Amount, Frequency & Duration) _____
 Use of Alcohol (Amount, Frequency & Duration) _____
 Use of Tobacco (Amount, Frequency & Duration) _____
 Betel Nut Chewing (Amount, Frequency & Duration) _____

Oral Health Condition

A. Check (✓) if present (✗) if absent

Date of Oral Examination					
Orally Fit Child (OFC)					
Dental Caries					
Gingivitis					
Periodontal Disease					
Debris					
Calculus					
Abnormal Growth					
Cleft Lip / Palate					
Others (supernumerary/mesiodens, malocclusions, etc.)					

B. Indicate Number

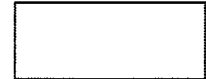
No. of Perm. Teeth Present					
No. of Perm. Sound Teeth					
No. of Decayed Teeth (D)					
No. of Missing Teeth (M)					
No. of Filled Teeth (F)					
Total DMF Teeth					
No. of Temp. Teeth Present					
No. of Temp. Sound Teeth					
No. of Decayed Teeth (d)					
No. of Filled Teeth (f)					
Total df Teeth					



Republic of the Philippines
 Department of Health
 Regional Office _____

(Municipality/City/Province)

File No. _____



Individual Patient Treatment Record

Name _____
 Surname _____ First Name _____ Middle Initial _____
 Date of Birth _____
 Place of Birth _____ Age _____ Sex _____
 Address _____
 Occupation _____
 Parent/Guardian _____

Other Patient Information (Membership)

National Household Targeting System – Poverty Reduction (NHTS-PR)
 Pantawid Pamilyang Pilipino Program (4Ps)
 Indigenous People (IP)
 Person With Disabilities (PWDs)
 PhilHealth (Indicate Number) _____
 SSS (Indicate Number) _____
 GSIS (Indicate Number) _____

Vital Signs

Blood Pressure: _____ Pulse Rate: _____
 Temperature: _____

Patient's / Guardian's Name and Signature

Medical History

Allergies (Please specify) _____
 Hypertension/ CVA
 Diabetes Mellitus
 Blood Disorders
 Cardiovascular / Heart Diseases
 Thyroid Disorders
 Hepatitis (Please specify type) _____

B. Services Monitoring Chart

Date Fluoride Varnish/Fluoride Gel, Pit and Fissure Sealant, Permanent Filling, Temporary Filling, Extraction

55 54 53 52 51 61 62 63 64 65

85 84 83 82 81 71 72 73 74 75

Legend:

Topical Fluoride Application:

FV – Fluoride Varnish

FG – Fluoride Gel

PFS – Pit and Fissure Sealant

PF – Permanent Filling (Composite, Am, ART)

TF – Temporary Filling

X – Extraction

O – Others

Date Fluoride Varnish/Fluoride Gel, Pit and Fissure Sealant, Permanent Filling, Temporary Filling, Extraction

18 17 16 15 14 13 12 11 21 22 23 24 25 26 27 28

48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38

Month/Quarter/Year _____
 Center for Health Development _____
 Municipality/City/Province _____

CONSOLIDATED ORAL HEALTH STATUS, SERVICES AND MEDICAL HISTORY MONTHLY REPORT

	Pregnant Women	Infant (0-11mos.)	Under Five Children					School Age Children					Adolescent 10-19 Y/O	Adult 20-60 Y/O	OLDER PERSONS 60+ Y/O	TOTAL ALL AGES	GRAND TOTAL
			1	2	3	4	TOTAL	5	6	7	8	9					
		F	F	F	M	F	F	F	F	F	F	M	F	M	F	M	F
NO. OF PERSON ATTENDED																	
NO. OF PERSON EXAMINED																	
A. MEDICAL HISTORY STATUS																	
1. Total No. with Allergies																	
2. Total No. with Hypertension/ CVA																	
3. Total No. with Diabetes Mellitus																	
4. Total No. with Blood Disorders																	
5. Total No. with Cardiovascular/Heart Diseases																	
6. Total No. with Thyroid Disorders																	
7. Total No. with Hepatitis																	
8. Total No. with Malignancy																	
9. Total No. with History of Previous Hospitalization																	
10. Total No. with Blood Transfusion																	
Total No. with Tattoo																	
B. RISK FACTOR / SOCIAL HISTORY STATUS																	
1. Total No. of Sugar Sweetened Beverages/Food Drinker/Eater																	
2. Total No. of Alcohol Drinker																	
3. Total No. of Tobacco User																	
4. Total No. of Betel Nut Chewer																	
C. ORAL HEALTH STATUS																	
1. Total No. with Dental Caries																	
2. Total No. with Gingivitis																	
3. Total No. with Periodontal Disease																	
4. Total No. with Oral Debris																	
5. Total No. with Calculus																	
6. Total No. with Dento Facial Anomalies (cleft lip/palate, Malocclusion, etc)																	
7. Total (d/f)																	
a. Total decayed (d)																	
b. Total filled (f)																	
8. Total (D/M/F)																	
a. Total Decayed (D)																	
b. Total Missing (M)																	
c. Total Filled (F)																	
D. SERVICES RENDERED																	
1. No. Given OP / Scaling																	
2. No. Given Permanent Fillings																	
3. No. Given Temporary Fillings																	
4. No. Given Extraction																	
5. No. Given Gum Treatment																	
6. No. Given Sealant																	
7. No. Completed Fluoride Therapy																	
8. No. Given Post-Operative Treatment																	
9. No. of Patient with Oral Abscess Drained																	
10. No. Given Other Services																	
11. No. Referred																	
12. No. Given Counseling / Education on Tobacco, Oral Health, Diet, Etc.																	
13. No. of Under Six Children Completed Toothbrush Drill																	
E. NO. OF ORALLY FIT CHILDREN (OFC)																	
1. OFC Upon Oral Examination																	
2. OFC Upon Complete Oral Rehabilitation																	

Prepared By: _____

 Signature Over Printed Name
 Designation