Health Care for the Homeless
INFORMATION RESOURCE CENTER
888/429-3300 • Fax 518/439-7612

#16. DENTAL FORMS

Dental clinic client survey (*TRA 6*)
Dental problems (*HPH 9*)
Dental professional volunteer application (*TRA 1*)
Dental program office survey (*TRA 10*)
Dental record (*CAM 9*)
Dental record (*TRA 9*)
Health history for dental referrals (*BAL 34*)
Dental referral (*THU 3*)
Medical/dental history (*TRA 8*)
Plan of treatment / *Plan de tratamiento* – Dental (*CAM 10*)

TRA 6

TRAVELERS AID SOCIETY OF RHODE ISLAND

HEALTH SERVICES

DENTAL CLINIC CLIENT SURVEY

Date:_____

Gender: male____female_____

Race: white____black____Hispanic_____other(please specify)_____

How long, in weeks, did you wait to see the dentist?_____

the hygienist ?_____

How long did you wait to be treated today ? 15 minutes or less_____

30 minutes_____one hour or more_____

In your opinion, was the medical history too detailed_____ or appropriate in length_____

Was your chief complaint treated in your first visit ?_____yes_____no

Were instructions regarding the care of your mouth or teeth given to you before you left the clinic ?_____yes_____no

Were you comfortable or encouraged in asking questions ?_____yes _____no

If you saw the dentist today, was a return appointment made for you to have your teeth cleaned ?_____yes____no Did you want an appointment?____yes____no

Were you treated courteously during your visit by:

the nurse who reviewed your medical history_____ yes_____no

the dental assistant _____yes_____no

the hygienist _____yes____no

the dentist _____yes____no

Do you have any comments that you wish to make ?

HOMELESS PERSONS HEALTH PROJECT

COUNTY OF SANTA CRUZ
HEALTH SERVICES AGENCY

CHART #_____

ISSUE #_____

CLIENT NAME_____ DATE:_____

Please draw a line through any order(s) which do not pertain to your client.

DENTAL PROBLEMS

S:_____

_____

_____

_____

O:_____

_____

_____

A1 DENTAL PROBLEMS:_____

_____

A2 REFERRED TO APPROPRIATE AREA AGENCIES:_____

MediCal 800 number

CHDP

Cabrillo College dental cleaning

Assessed for knowledge deficits

Instructed re: proper oral hygiene; soft toothbrush; flossing

Advised of resources for oral hygiene maintenance; HPHP offers free tooth-brush/toothpaste; may use baking soda for brushing

Educate re: criteria that must be met for county emergency DDS referral

_____

_____

P Client to follow-up as above. Client to initiate contact with HPHP as necessary for follow-up

_____

SIGNED_____ Page #_____

HSA-756G

TRA J

TRAVELERS AID SOCIETY OF RHODE ISLAND
177 UNION STREET
PROVIDENCE, RI 02903
(401) 521-2255
FAX (401) 421-7410

OFFICE COPY

HEALTH CARE SERVICES PROGRAM
DENTAL PROFESSIONAL VOLUNTEER APPLICATION

Social Security # ___-___-____ Date of Birth _____ /_____ /_____

Name _____ Employer _____

Address _____ Address _____

City _____ Zip _____ City _____ Zip_____

Telephone _____ Telephone _____

Fax # _____

Professional License #_____

Please enclose evidence or current copies of the following:

- Copy of RI professional license
- Copy of cover page of malpractice insurance
- Copy of CPR certification
- Evidence or declination of HBV vaccination
- Date of last PPD (within last 12 mos.)
- Evidence of Measles/Rubella Vaccine

Please identify your profession by circling one of the following.

DDS, DMD, RDH, CDA, OTHER _____

How did you hear about the program? _____

What is your specialty? _____Additional skills you would like to contribute _____

_____

Are you bi-lingual? _____ language _____If dentist, are you willing to supervise auxiliary personnel? _____

PROFESSIONAL REFERENCE

Name: _____ Address: _____

City: _____ Zip: _____

Please circle preferred time you would like to volunteer:

M T W TH F morning _____ afternoon _____

We are asking for a minimum of 3 hours four times a year. If you are able and willing to do more we can discuss details. The need is great.

INTEROFFICE USE ONLY
OR Date: _____
Start Date:_____

_____ _____
Signature Date

TRA 10-1

TRAVELERS AID SOCIETY OF RHODE ISLAND
HEALTH CARE SERVICES
DENTAL PROGRAM OFFICE SURVEY
(401) 521-2255

A. Identification

1. Survey date: _____ Evaluator: _____

B. General

1. Is adequate convenient parking available? _____ Yes _____ No

	E	G	A	NI	P
2. Condition of building:	___	___	___	_____	_____

3. Neighborhood: ___Rural ___Suburban ___City
4. Neighborhood: ___Commercial ___Residential ___Industrial ___Farm
5. Is there handicapped access? _____Yes _____No
6. Is there access to public transporation? _____Yes _____No

C. Waiting Room

1. Is there adequate seating? _____ Yes _____ No
2. Overall appearance of area: ___E ___G ___A ___NI ___P

D. Business Area

1. Is a separate business area present? ___Yes ___No
2. Is the office computerized? ____Yes ____No
3. Cleanliness and neatness of area: ___E ___G ___A ___NI ___P

E. Appointments

1. What is the waiting time for appointments (in weeks)?:

   New Patient:_____weeks

   Continuing care:_____weeks

2. How are emergency visits handled:

   ____ seen immediately
   ____ same day
   ____other:_____

F.
Record Keeping

	Yes	No
1. Are medical "alerts" conspicuously noted on the record when indicated?	_____	_____
2. Is there a complete, current medical history in the record (updated at least every six months or at recall)?	_____	_____
3. Indicates necessary premedications and current meds:	_____	_____
4. Is the following information recorded:		
blood pressure	_____	_____
existing restorations	_____	_____
caries	_____	_____
missing teeth	_____	_____
prosthetic appliances	_____	_____
soft/hard tissue exams	_____	_____
periodontal status	_____	_____
problems/diagnosis	_____	_____
sequential treatment plan	_____	_____
5. Do entries include:		
date of service	_____	_____
tooth and surfaces	_____	_____
drugs given/administered/prescribed	_____	_____
doctor's signature	_____	_____

6. How many records were reviewed? _____

7. How many x-ray films were reviewed? ___ FMS ___ BW sets ___ Pan ___PA's

8. The quality of the x-rays is: ___ E ___ G ___A ___ NI ___ P

9. Appropriate x-rays taken/obtained for all new patients? ___ A ___ U ___S ___ N
Describe: _____

10. Are all x-rays clearly dated and identified? ___ A ___ U ___ S ___ N

11. Does the record system contain a specific area to indicate:

	Yes	No
Updated medical history?	_____	_____
Periodontal pocket depths?	_____	_____
Tooth charting?	_____	_____

G.
Medical Emergencies

	Yes	No
1. Is there a medical emergency kit?	_____	_____
2. Are the medications in the kit current?	_____	_____
3. Is portable oxygen or Ambu bag available?	_____	_____
4. Is the dentist currently certified in CPR?	_____	_____
5. Is the staff currently certified in CPR?	_____	_____

H. Radiographs and Mercury Safety

1. Lead aprons used? _____ Yes _____ No
2. How many x-ray machines are in the office? _____ machines
   Describe:
3. Are radiation badges worn by clinical staff? _____ Yes _____ No
4. Are closed amalgam capsules used? _____ Yes _____ No
5. Is scrap amalgam stored appropriately? _____ Yes _____ No
6. Is the environment free of mercury? _____ Yes _____ No

I. Anesthesia

1. Type of anesthesia offered:
   _____ Local anesthesia _____ None
   _____ Nitrous Oxide _____ Oral premedication
   _____ IV Sedation _____ General Anesthesia
2. Are aspirating syringes used? _____ Yes _____ No
3. Are disposable needles used? _____ Yes _____ No
4. Is there a recovery room for general anesthesia or IV sedation? _____ Yes _____ No _____ N/A

J. Sterilization, Asepsis & Infection Control

1. Are all instruments *sterilized* that can be? _____ Yes _____ No
   By what method(s):
   _____ Steam autoclave _____ Chemiclave
   _____ Dry heat (at least 340F for 60 min)
2. What, if anything, is "cold sterilized" (disinfected)?
3. Are disposable supplies always discarded after single use? (such as prophy cups, saliva ejectors, etc.) _____ Yes _____ No
4. Are all instruments stored in a sealed container after sterilization? _____ Yes _____ No
5. Are handpieces sterilized after each patient? _____Yes _____No
6. Is there an OSHA training schedule available ? _____Yes _____No
7. Is there an OSHA log book containing employees medical records? _____Yes _____No
8. Are gloves worn for all patients? _____Yes _____No
9. Are masks worn for all patients? _____Yes _____No
10. Is eye protection worn for all patients? _____Yes _____No
11. Are there points of use sharps disposal containters? _____Yes _____No
12. Are there containers for the disposal of medical waste? _____Yes _____No
13. Is Medical Waste stored in an appropriate area? _____Yes _____No
14. Is there a log book for sterilizer checks? _____Yes _____No

TRA 10-4

K.
Treatment Rooms

1. Total number of treatment rooms/operatories: _____ rooms
2. Is there adequate privacy? _____ Yes _____ No
3. Is the lighting adequate? _____ Yes _____ No
4. Condition of equipment: ____ ____ ____ ____ ____
5. Overall appearance of rooms: ____ ____ ____ ____ ____
6. Age of equipment in years: _____ 0-10 _____ 11-20 _____ 21-30 _____ 30-40 _____ >40

L.
Staff

1. Number of dentists practicing at this office: _____

1a. Names of dentists: Specialty

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

1b. Number of hygienists at this office: _____

____ FT ____ PT ____ RDH hrs/wk

1c. Name of Dental Coordinator: _____

2. How many non-DDS, non-RDH staff? _____ FTE auxiliary/office staff

	E	G	A	NI	P
3. Appearance of staff:	____	____	____	____	____
4. Friendliness of staff:	____	____	____	____	____
5. Professional behavior of staff:	____	____	____	____	____

_____
_____
_____
_____

M.
Miscellaneous

1. Evaluators overall impression of acceptability:

Outstanding _____
Excellent _____
Good _____
Fair _____
Unacceptable _____

Comments: _____

N. Explanation of Symbols:

E Excellent

G Good

A Average/Always

NI Needs Improvement

P Poor

N Never

S Seldom

U Usually

CAM 9

CAMILLUS HEALTH CONCERN
DENTAL RECORD

DATE _____ NAME _____

ALERT

BIRTHDAY _____ CHC # _____ SEX _____

	YES	NO
1. ARE YOU UNDER THE CARE OF A PHYSICIAN? (ESTA USTED BAJO EL TRATAMIENTO DE ALGÚN MEDICO) REASON (RAZÓN): _____	☐	☐
2. ARE YOU TAKING ANY MEDICINE OR DRUGS? (ESTA TOMANDO ALGÚN MEDICAMENTO O DROGA) LIST (NÓMBRELOS): _____	☐	☐
3. HAVE YOU BEEN HOSPITALIZED IN THE LAST 5 YEARS? (HA ESTADO USTED HOSPITALIZADO EN LOS PASADOS 5 AÑOS) WHY? (POR QUE?): _____	☐	☐
4. ARE YOU ALLERGIC TO ANYTHING (DRUGS, FOODS)? (ES USTED ALÉRGICO A ALGO (MEDICINAS, COMIDAS) LIST (NÓMBRELOS): _____	☐	☐
5. HAVE YOU EVER HAVE ANY OF THE FOLLOWING? (HA TENIDO USTED ALGUNO DE LOS SIGUIENTES)		
HEART TROUBLE (PROBLEMAS DEL CORAZÓN) _____	☐	☐
RHEUMATIC FEVER (FIEBRE REUMÁTICA) _____	☐	☐
HIGH BLOOD PRESSURE (PRESIÓN ALTA O BAJA) _____	☐	☐
LIVER DECEASE (HEPATITIS) (PROBLEMA DEL HÍGADO) _____	☐	☐
EPILEPSY (SEIZURES) (EPILEPSIA) _____	☐	☐
CANCER _____	☐	☐
TUBERCULOSIS _____	☐	☐
ANEMIA _____	☐	☐
BLOOD DISEASE (PROBLEMAS DE SANGRE) _____	☐	☐
ASTHMA (ASMA) _____	☐	☐
A.I.D.S.-C.I.D.A. (S.I.D.A) _____	☐	☐
6. DO YOU SMOKE? PACKS PER DAY _____ (USTED FUMA? PAQUETES POR DÍA)	☐	☐
7. ARE YOU PREGNANT? _____ (ESTA USTED EMBARAZADA?)	☐	☐

8. IS THERE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK WE KNOW ABOUT, OR IS THERE ANY ACTIVITY YOUR DOCTOR SAYS YOU CAN NOT DO? (SI HAY ALGUNA ENFERMEDAD, CONDICIONA O PROBLEMA NO MENCIONADO ARRIBA QUE USTED PIENSE DEBAMOS SABER, O ALGUNA ACTIVIDAD QUE SU DOCTOR NO LE PERMITE HACER?) IF SO, EXPLAIN (SI ES ASÍ EXPLIQUE) _____

DENTAL HISTORY (HISTORIA DENTAL)

1. REASON FOR VISIT? (RAZÓN DE SU VISITA) _____
2. LAST DENTAL VISIT? (ULTIMA VISITA) _____ LAST COMPLETE EXAM (FECHA, EXAMEN COMPLETO) _____
3. DO YOU PREFER A LOCAL ANESTHETIC (NOVOCAINE) FOR MOST DENTAL TREATMENT? YES _____ NO _____ (PREFIERE USTED ANESTESIA LOCAL (NOVOCAÍNA) PARA LA MAYORÍA DE SU TRATAMIENTO DENTAL)
4. HAVE YOU EVER HAD ANY SERIOUS TROUBLE ASSOCIATED WITH PREVIOUS DENTAL TREATMENT? _____ (HA TENIDO USTED PREVIAMENTE ALGÚN PROBLEMA SERIO RELACIONADO CON EL TRATAMIENTO DENTAL)
5. DOES DENTAL TREATMENT MAKE YOU NERVOUS? NO____ SLIGHTLY____ MODERATELY ____ EXTREMELY____ (EL TRATAMIENTO DENTAL LO PONE NERVIOSO?) (NO) (UN POCO) (BASTANTE) (EXTREMADAMENTE)
6. HAVE YOU EVER BEEN TREATED FOR PERIODONTAL DISEASE (GUN DISEASE, PYORRHEA, TRENCH MOUTH) (HA SIDO TRATADO POR ENFERMEDAD PERIODONTAL (ENFERMEDAD DE ENCÍAS, PIORREA, GINGIVITIS ULCERATIVA) _____
IF YES WHEN (SI ES ASÍ CUANDO) _____

_____ Signature (Firma)

_____ Date (Fecha)

TRA 9-1

Dental Record

Name_____ SS#_____

DOB_____

Allergies:_____

Examination

Findings: Normal = (-); Abnormal = (+)

Date:_____

Comments

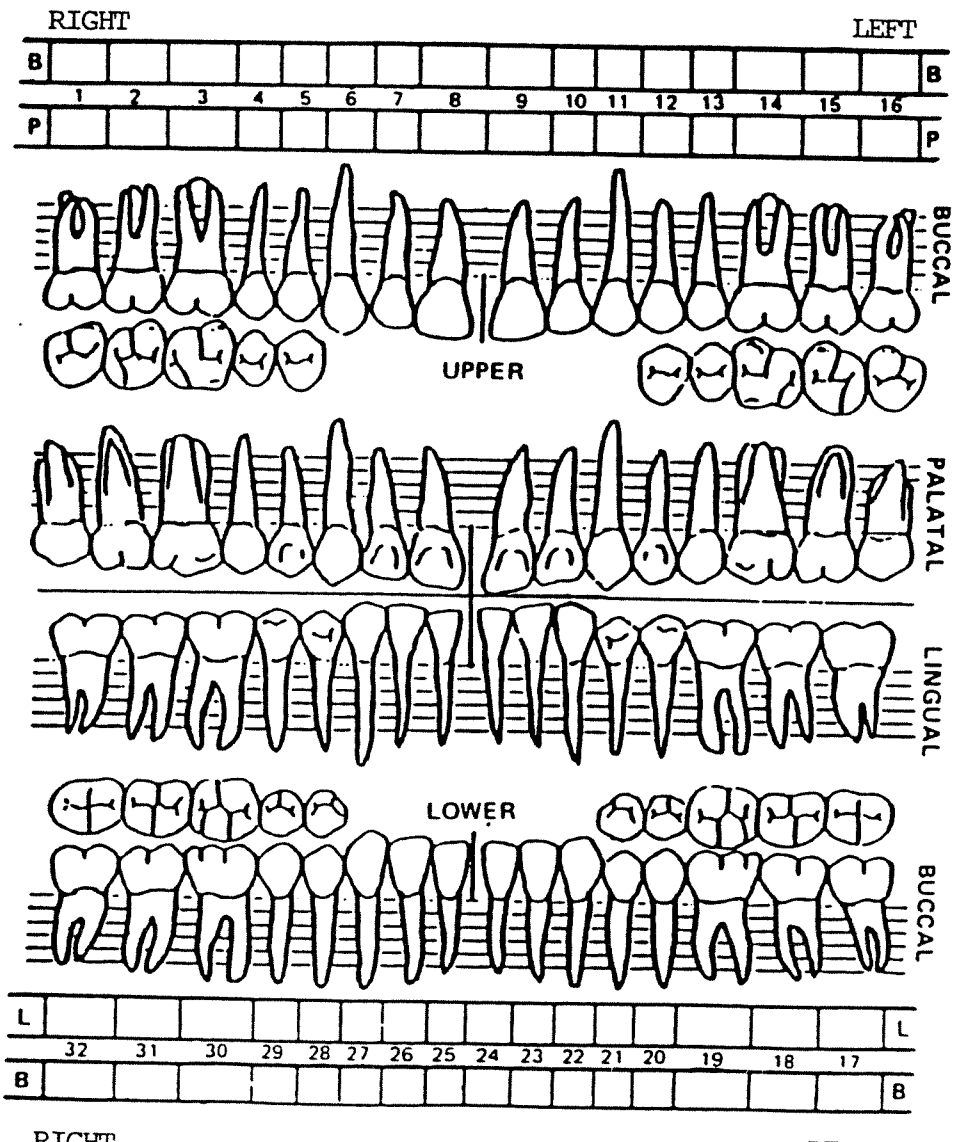
General Appraisal	-	+
Head (skin, face, eyes)	-	+
Lips	-	+
Neck (Nodes, glands)	-	+
Oral soft tissue	-	+
Periodontium	-	+
Teeth	-	+

Occlusion:_____

Evaluation: Specific Presenting Problem:_____

Dental Chart

Caries in red, restorations in blue



Treatment Plan:

A. Immediate Dental Need/s.

1.

2.

B. Routine Dental Need/s.

1.

2.

3.

4.

5.

6.

7.

8.

ALERT!_____

TRA 9-2

NAME

DATE	SERVICES RENDERED	SIGNATURE	DATE	SERVICES RENDERED	SIGNATURE

BAL 34

HEALTH CARE FOR THE HOMELESS, INC. ◆ 111 PARK AVENUE ◆ BALTIMORE, MD 21202 ◆ (410) 837-5533

HEALTH HISTORY FOR DENTAL REFERRALS

CLIENT NAME: _____ HCH#: _____

PROVIDER: _____ DATE: _____

HAS CLIENT HAD ANY OF THE FOLLOWING? INDICATE WITH A CHECK MARK (✓) OR X.
(EXPLAIN TREATMENT FOR ANY CONDITIONS PRESENT).

_____HEART PROBLEM
_____HEART MURMUR. IF YES, WAS CLIENT PROVIDED WITH SBE PROPHYLAXIS? _____
_____HIGH BLOOD PRESSURE
_____FAINTING OR DIZZINESS
_____CIRCULATORY PROBLEMS
_____ASTHMA
_____COPD OR OTHER PULMONARY CONDITION
_____ KIDNEY DISEASE
_____DIABETES
_____ARTHRITIS
_____EPILEPSY OR SEIZURES
_____SPEECH PROBLEMS
_____VISION OR EYE PROBLEMS
_____DEAFNESS OR HEARING PROBLEMS
_____USES WHEELCHAIR OR CRUTCHES
_____NEEDS ASSISTANCE TO WALK
_____SINUS PROBLEMS
_____PREGNANCY
_____SICKLE CELL DISEASE
_____EXCESSIVE BLEEDING

_____ HEPATITIS SIGNIFICANT BLOOD WORK RESULTS _____

_____ HIV IF NO, DATE OF LAST TEST _____
RISK FACTORS FOR HIV _____
(IF HIV+, SEND COPY OF CBC, CD4, CHEM, PT/PTT WITHIN PAST MONTH. REFER TO HIV CLINIC)

_____TUBERCULOS DATE OF LAST TB TEST OR CXR _____

_____SEXUALLY TRANSMITTED DISEASE

_____ALLERGY TO MEDICATION _____ALLERGY TO FOOD _____ALLERGY TO NOVACAINE OR NUMBING AGENT

PLEASE NOTE ANY ANTIBIOTIC AND/OR ANALGESIA PROVIDED TO CLIENT:

I AUTHORIZE RELEASE OF THE ABOVE INFORMATION TO THE DENTAL CLINIC. _____
(CLIENT SIGNATURE)

THU 3

THUNDERMIST HEALTH ASSOCIATES, INC.
383 ARNOLD STREET
WOONSOCKET, RI 02895

H.C.H. DENTAL REFERRAL FORM

REFERRAL DATE: _____

PATIENT NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

****

MEDICAL RECORD #: _____

REASON FOR REFERRAL: _____

_____

_____

_____

_____

****

FOR DENTIST/HYGIENIST USE ONLY:

DENTAL CARE PLAN: _____

_____

_____

_____

_____

_____

NEXT VISIT: _____

****

COMMENTS: _____

_____

_____

4/97
clv

1KA8

TRAVELERS AID SOCIETY OF RI
177 UNION STREET
PROVIDENCE, RI 02903

REVIEWED BY_____DATE_____
REVIEWED BY_____DATE_____
REVIEWED BY_____DATE_____
REVIEWED BY_____DATE_____

MEDICAL/DENTAL HISTORY

PATIENT NAME:_____ TODAY'S DATE:_____
Last First Middle Initial Mo. Day Year

The following information is considered confidential medical information. It may be necessary to share this with your case worker in order to coordinate services.

Answer the following questions by circling Y(Yes) or N(No) to which ever applies:

If Yes, Explain

Have you been hospitalized or had any serious illness? . . . . . Y N
Has there been any changes in your general health within the past year? . . . . . Y N
Do you have allergies or bad reactions to any medications, prescription, or over the counter? . . . . . Y N
If yes, list_____
Do you take or apply any medicine (including birth control pills)? . . . . . Y N
If yes, list (including over the counter)_____

Do you have a physician? Y N Name:_____
Address:_____
Date of last physical: Mo.____ Yr.____ Place of exam:_____

Do you have a dentist? Y N Name:_____
Address:_____
Date of last dental exam: Mo.____ Yr.____ Last dental X-rays:_____
FEMALES ONLY: Are you pregnant, or do you suspect you may be? Y N Due date:_____

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?:

MEDICAL		EXPLAIN			EXPLAIN
Rheumatic Fever	Y N		Blood Transfusion	Y N	
Heart Murmur	Y N		Blood Refused for Donation	Y N	
Valve Disorder(heart) or Surgery	Y N		Bleeding Disorder, i.e. Hemophilia	Y N	
Artificial Joint Replacement	Y N		Benign Tumor or Cancer	Y N	
Sugar Diabetes	Y N		Radiation Therapy	Y N	
Yellow Skin or Eyes	Y N		Breathing difficulties	Y N	
Hepatitis	Y N		Heartburn, Stomach disorders	Y N	
Tuberculosis	Y N		Hearing problems	Y N	
High/Low Blood Pressure	Y N		Eye problems	Y N	
Kidney Problems	Y N		Sexually Transmitted Disease	Y N	
Seizures, Epilepsy	Y N		Last treated_____		
Thyroid Disorder	Y N		Intimate contact with anyone at risk for AIDS	Y N	
Heart Trouble, Surgery, Angina, etc.	Y N		IV Drug User	Y N	
Pacemaker	Y N		Multiple Sex Partners	Y N	
Stroke	Y N		Intimate contact with bisexuals	Y N	
Drug Abuse problem	Y N		Emotional problems	Y N	
Alcohol Problem	Y N		Received treatment for emotional problem	Y N	
Treatment for Substance Abuse	Y N		If so, where?_____		
Do you smoke? # of packs/day___	Y N				

DENTAL		EXPLAIN			EXPLAIN
Do you have pain?	Y N		Do you brush your teeth?	Y N	
If yes, where?_____			If so, how often?_____		
Is the pain constant?	Y N		Do you need a tooth brush, tooth paste, floss?	Y N	
Is the pain associated with hot/cold or sweets?	Y N		Do you floss?	Y N	
Do you take something for the pain?	Y N		Do you know how to floss?	Y N	
If yes, what?_____			Do your gums bleed?	Y N	
Is there anything unusual about your mouth?	Y N		If yes, when?_____		
Tooth pulled?	Y N		Root canal therapy?	Y N	
Fillings?	Y N		Do you have any questions?	Y N	
Removable teeth?	Y N				
Bad experiences with previous dental treatment?	Y N				
If so, explain_____					

I have answered the above questions honestly and hereby grant permission to administer dental care to: Travelers Aid Society of RI 177 Union Street, Providence, RI 02903.

Signature of Patient:_____ Date:_____

Signature of Responsible Adult if Under 16:_____

BAL 34

HEALTH CARE FOR THE HOMELESS, INC. ◆ 111 PARK AVENUE ◆ BALTIMORE, MD 21202 ◆ (410) 837-5533

HEALTH HISTORY FOR DENTAL REFERRALS

CLIENT NAME: _____ HCH#: _____

PROVIDER: _____ DATE: _____

HAS CLIENT HAD ANY OF THE FOLLOWING? INDICATE WITH A CHECK MARK (✓) OR X.
(EXPLAIN TREATMENT FOR ANY CONDITIONS PRESENT).

_____HEART PROBLEM
_____HEART MURMUR. IF YES, WAS CLIENT PROVIDED WITH SBE PROPHYLAXIS? _____
_____HIGH BLOOD PRESSURE
_____FAINTING OR DIZZINESS
_____CIRCULATORY PROBLEMS
_____ASTHMA
_____COPD OR OTHER PULMONARY CONDITION
_____ KIDNEY DISEASE
_____DIABETES
_____ARTHRITIS
_____EPILEPSY OR SEIZURES
_____SPEECH PROBLEMS
_____VISION OR EYE PROBLEMS
_____DEAFNESS OR HEARING PROBLEMS
_____USES WHEELCHAIR OR CRUTCHES
_____NEEDS ASSISTANCE TO WALK
_____SINUS PROBLEMS
_____PREGNANCY
_____SICKLE CELL DISEASE
_____EXCESSIVE BLEEDING

_____ HEPATITIS SIGNIFICANT BLOOD WORK RESULTS _____

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(IF HIV+, SEND COPY OF CBC, CD4, CHEM, PT/PTT WITHIN PAST MONTH. REFER TO HIV CLINIC)

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_____ALLERGY TO MEDICATION _____ALLERGY TO FOOD _____ALLERGY TO NOVACAINE OR NUMBING AGENT

PLEASE NOTE ANY ANTIBIOTIC AND/OR ANALGESIA PROVIDED TO CLIENT:

I AUTHORIZE RELEASE OF THE ABOVE INFORMATION TO THE DENTAL CLINIC. _____
(CLIENT SIGNATURE)

CAM 10

PLAN OF TREATMENT (PLAN DE TRATAMIENTO)

PROBLEMS (PROBLEMAS)	TREATMENT (TRATAMIENTO)	COST (COSTO)	FINAL TREATMENT (TRATAMIENTO FINALIZADO)