

# ***Dental Health Services***

## ***Non-Admitted Patients***

### **Public Hospital Monthly Return**

**127 S2**



Refer to the Agency Information Management System Manual for instructions on completing this form.

<b>Agency:</b>	
<b>Output:</b>	<b>Period:</b>
	<b>Year:</b>
<b>Type of Service</b>	<b>Occasions of Service</b>
1 Dental Emergency Treatment	
2 Dental General Outpatient Treatment	
3 TOTAL	
<b>Only public non-admitted patient occasions of service are counted on this return. Services for private patients (including compensables) are excluded.</b>	
Signed (Chief Executive Officer):	Date: