



STATE OF WEST VIRGINIA  
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Joe Manchin III  
Governor

Martha Yeager Walker  
Secretary

**POLICY STATEMENT**

**TO:** Local Health Departments, Dental Clinics and EPSDT Providers

**FROM:** Greg Black, D.D.S., Dental Director, Oral Health Program  
Carol A. Brown, Coordinator, Children's Dentistry Project

**DATE:** September 14, 2006

**RE:** Water Test Kits/Fluoride Dispensing

It is the policy of the Oral Health Program to work with local health departments, dental clinics, and EPSDT providers to supply water test kits to families to check the level of fluoride in their drinking water in order to prescribe fluoride supplements when needed. To receive the kits and supplements your facility must have a clinician who can interpret the water test results and legally prescribe fluoride supplements. Proper dosage is based on the levels of fluoride found in the drinking water and the age of the patient; therefore, **no family should receive fluoride supplements without first having their water tested.**

The clinician's name and address must be included on the form located inside the water test kit in order for the results to be sent to the clinician. **Results are not sent to the patient.** The water test kits have prepaid postage and fluoride supplements are provided free of charge to clinicians to dispense to patients. For a facility/clinician to participate, you must complete and sign a Memorandum of Understanding and a Fluoride/Water Test Kit Order Form and return it to the address listed on the forms.

The facility/clinician must send the Water Test Kit Log and Fluoride Dispensing Log by the **10<sup>th</sup>** of **every** month to OMCFH/Oral Health Program, 350 Capitol St., Room 427, Charleston, West Virginia 25301-3714.

The Office of Laboratory Services will complete the water fluoridation testing and send the results to the Oral Health Program (OHP). The data is entered and the OHP will send the water test results to the clinician where a fluoride prescription can be written or supplements dispensed.

If the test report shows elevated fluoride levels (1.3 ppm or above), the Oral Health Program will notify the provider and request a second sample so the test may be repeated for accuracy. As with all laboratory test results, it is the providers' responsibility to notify the patient of the findings.

Questions concerning this memorandum may be directed to the Children's Dentistry Project at 1-800-642-8522. Your cooperation in complying with these guidelines is appreciated.

*Attachments: Water Test Kit/Fluoride Dispensing Protocol with dosage schedule, Memorandum of Understanding, Fluoride/Water Test Kit Order Form, Fluoride Dispensing Log, Water Test Kit Log*

cc: Tammy Vickers  
Charlotte Billingsley  
Becky Payne  
Larry Duffield



## WATER TEST KITS/FLUORIDE DISPENSING POLICY STATEMENT

### MEMORANDUM OF UNDERSTANDING

I understand the instructions contained in the memorandum "Water Test Kits/Fluoride Dispensing Policy Statement." I will comply with the protocol as issued by the Bureau for Public Health, Office of Maternal, Child and Family Health, Children's Dentistry Project with regard to water testing procedures for fluoride when I become aware that my patient may need to have his/her water tested so that I can prescribe adequate fluoride supplements.

Please sign and return this page to the following address:

WV Department of Health and Human Resources  
Materials Management Office  
Attn: Tammy Vickers  
900 Bullitt Street  
Charleston, WV 25302

PROVIDER/CLINIC NAME \_\_\_\_\_

PROVIDER/CLINIC ADDRESS \_\_\_\_\_

PROVIDER/CLINIC TELEPHONE \_\_\_\_\_

\_\_\_\_\_  
PROVIDER/CLINIC ADMINISTRATOR'S SIGNATURE DATE



## WATER TEST KIT/FLUORIDE DISPENSING PROTOCOL

1. Never give a water test kit to a family whose child is younger than 6 months of age. **No form of fluoride supplementation should be given to infants until 6 months of age.**
2. Do not dispense fluoride supplements or write a prescription to a family unless their water source has been tested.
3. The dosage chart cited below is to be followed when prescribing/dispensing fluoride supplements:

<b>Recommendations for Fluoride Supplemental</b>			
<b>Age</b>	<b>Water fluoride content in ppm</b>		
	<b>&lt;0.3</b>	<b>0.3-0.6</b>	<b>&gt;0.6</b>
<b>Birth-6 months</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>6 months-3 yrs.</b>	<b>0.25</b>	<b>0</b>	<b>0</b>
<b>3 years-6 years</b>	<b>0.50</b>	<b>0.25</b>	<b>0</b>
<b>6 years-16 years</b>	<b>1.00</b>	<b>0.50</b>	<b>0</b>

4. A six month supply of fluoride supplements should be the maximum amount of supplement dispensed at one time.
5. Do not dispense fluoride supplements to children who are Medicaid/CHIPS eligible because these programs provide these prescription benefits.
6. Fluoride supplements purchased by the Oral Health Program will be .25 mg only and should be dispensed to low-income, non-eligible Medicaid/CHIPS children.



## FLUORIDE/WATER TEST KIT ORDER FORM

I AM REQUESTING THE FOLLOWING:

\_\_\_\_\_ FLUORIDE TABLETS

\_\_\_\_\_ FLUORIDE DROPS

\_\_\_\_\_ FLUORIDE TEST KITS

THESE FLUORIDE SUPPLEMENTS/WATER TEST KITS WILL BE DISPENSED IN MY OFFICE/CLINIC TO CHILDREN IN ACCORDANCE WITH THE "WATER TEST KITS/FLUORIDE DISPENSING POLICY STATEMENT PROTOCOL", ISSUED BY THE OFFICE OF MATERNAL, CHILD AND FAMILY HEALTH/ORAL HEALTH PROGRAM (OMCFH/OHP). MY OFFICE WILL PROVIDE OMCFH/OHP THE NAMES OF ALL CHILDREN WHO RECEIVED FLUORIDE SUPPLEMENTS/WATER TEST KITS PROVIDED BY THIS OFFICE/CLINIC.

PLEASE MAIL THIS ORDER FORM TO THE FOLLOWING ADDRESS:

WV Department of Health & Human Resources  
Materials Management  
Tammy Vickers  
900 Bullitt Street  
Charleston, WV 25301

\_\_\_\_\_  
**Provider Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Provider/Agency Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Address**

\_\_\_\_\_

**Note: WVDHHR/Materials Management Office and OMCFH reserve the right to reduce fluoride orders based upon availability and/or funding.**



## FLUORIDE DISPENSING LOG

Provider \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_

Return this form by the **10<sup>th</sup>** of **every** month to:  
Office of Maternal, Child and Family Health  
Children's Dentistry Project  
350 Capitol Street, Room 427  
Charleston, WV 25301-3714

TABLETS/ DROPS	QUANTITY DISPENSED	DATE DISPENSED	PATIENT'S NAME	PARENT'S NAME	COUNTY OF RESIDENCE

I certify that the fluoride dispensed to the patients listed meets the Office of Maternal, Child, and Family Health/Children's Dentistry Project protocol.

\_\_\_\_\_  
Signature

This information is legally privileged and confidential under applicable law and is intended for the use of the individual or entity named above. If the recipient of this information is not the above-named recipient, you are hereby notified that any dissemination, copy or disclosure of this communication is strictly prohibited.



## WATER TEST KIT LOG

Provider \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Phone \_\_\_\_\_

Return this form by the **10<sup>th</sup>** of **every** month to:  
Office of Maternal, Child and Family Health  
Children's Dentistry Project  
350 Capitol Street, Room 427  
Charleston, WV 25301-3714

DATE	CHILD'S NAME	PARENT'S NAME	COUNTY OF RESIDENCE

I certify that the water test kit dispensed to the patients listed meets the Office of Maternal, Child and Family Health, Children's Dentistry Project protocol.

\_\_\_\_\_  
**Signature**

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