

Oral Health Assessment Form

DATE _____

Name of Resident _____

Completed by _____

DOB _____

Does resident have a registered dentist? Yes/No/Unsure Name of GDP if known _____

Details of registered dentist _____

When did the resident last attend a dentist visit (approx) _____

Dental status	Yes tick	No tick	Comments/ instructions for care home (manager/staff)
Does the resident have any natural teeth?	More than 10 Less than 10		Encourage independence with Cleaning morning and night with Small headed brush and fluoride toothpaste
Does the resident wear a denture/s?	<ul style="list-style-type: none"> • Upper • lower 		Supervise /help with cleaning dentures morning and night with mild soap and water; rinse dentures after meals. Leave dentures out overnight if acceptable to resident
Does the resident complain of anything orally?			Discuss with resident/family and if in agreement, complete a referral or make an appointment for resident to see a dentist.
Oral Hygiene ability			<input type="checkbox"/> Independently <input type="checkbox"/> Assisted with brushing <input type="checkbox"/> Fully assisted
Does the resident wear dentures?			Check to see if dentures is broken or is loose and needs denture adhesive.
Is the denture/s named?			If denture/s are not named ask the resident if he/she would like them to be marked. Contact your local dental laboratory or this service.
Soft tissue check	yes	No	Comment on advice to be given
Is the tongue coated?			If the tongue is coated brush gently with a soft toothbrush and mild toothpaste or tongue cleaner.
Does the resident have a dry mouth?			Clean lips and oral soft tissues with water and apply water-based gel. Offer frequent fluids and/or iced water.
Are there any ulcers, red or white patches present?			Should you find any patches in the mouth, monitor. If is has not healed after 3 weeks seek a dentist.

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Findings	If Yes (circle below)		
Does the resident have broken teeth?	1	2	3 +
Does the resident appear to have food and debris in-between the teeth?	Nothing 0 <input type="checkbox"/>	a small amount ++ <input type="checkbox"/>	quite a lot +++ <input type="checkbox"/>
Oral Care Plan Please indicate what resident uses	Yes	No	Comments/ instructions for care home (manager/staff)
Manual brush			To brush the along the gum margins and teeth 2 x daily
Adapted toothbrush			Indicate if resident needs the toothbrush to be adapted for better grip
Electric toothbrush			To place toothbrush along the gum margins . Brush 2 x daily
Interdental brushes (brushes for cleaning in-between the teeth)			use interspace brushes in-between the teeth if resident requires assistance and discard after use.
Mouthwash			Fluoride mouthwash can be used daily. Corsodyl mouthwash should only be used if indicated by a dental professional.
Dentures			Encourage resident to leave denture/s out at night. Soak in water. Brush denture/s with a toothbrush, soap and water.
Denture pot			Plastic denture pot should be named

It is recommended that residents should have a review with a dentist at least once every 2 years.
This is organised by the care home and/or next of kin

NOTES:
Write any preferences the resident has with oral care such as products eg. Preferred toothpaste/mouthwash, type of toothbrush, fixative etc..

I am concerned and would like this person to see a dental professional

This person has expressed that he/she would like to see a dentist

Review residents' oral health again on _____