|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Date:** |  |
| **Is the service user able to use a tooth brush?** | Yes | No | If “No” what is the reason? |
| **Is the service user able to press the toothpaste alone?** | Yes | No | If “No” what is the reason?  |
| **Favourite brand of toothpaste:**  |  |
| **Preferred type of toothbrush** |  Manual Battery  |
| **How many times does the service user wish to have their teeth cleaned a day?\* *Brushing twice a day is recommended***  |  |
| **Does the service user have dentures?** | Yes | No | Additional Information: |
| **Are dentures clean?** | Yes | No |  |
| **Are dentures plastic?** | Yes | No |  |
| **Are dentures metal** | Yes | No |  |
| **Does the service user have:**  | None Full set Bottom Top |
| **When are the dentures worn?**  | All day Meal times only Not worn |
| **Are the dentures kept in a pot?** | Yes No |
| **Are the lips** | Soft Dry Cracked |
| **Does the service user have cold sores?** | Yes No |
| **Is there any halitosis breath (bad breath)?** | Yes No |
| **Does the tongue look pink?** | Yes No |
| **Does the tongue move freely?** | Yes No |
| **Are the gums** | Pink Red Bleeding when brushed |
| **Overall oral condition** | Healthy Mild dysfunction  Moderate dysfunction Severe dysfunction |
| **Are there any mouth ulcers, lumps or white patches? Please detail** |  |
| **Does the service user require a referral to dentist?**  | Yes No |
| **When was the last known visit to the dentist?** | Date…………………………………………….. |
| **Does the service user have a preferred dentist?** **(If yes, give details)** | Yes No |
| **Any other relevant information** |  |
| **Date to be reviewed:** |  |
| **Completed by ; Name**  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Date:** |  |
|

|  |
| --- |
| Teeth Missing: |
|  |
| Dentures: |
| Upper Lower Part\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

Image result for dental layout of teeth |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Date |  |  |  |  |  |  |  | Signed |
| Brushing |
| Upper teeth |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Lower teeth |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
| Dentures |
| Cleaned | Yes No  | Yes No  | Yes No  | Yes No  | Yes No  | Yes No  | Yes No  |  |
| Yes No  | Yes No  | Yes No  | Yes No  | Yes No  | Yes No  | Yes No  |  |
| Other |
| any ulcers or bleeding (include placement) |  |  |  |  |  |  |  |  |
| Any other comments |  |  |  |  |  |  |  |  |
| Signed |  |  |  |  |  |  |  |  |