Oral Health Risk Assessment

A response in a red box – contact dentist
A response in an orange box – may require more intensive oral health input, consider seeking advice from a dental professional.

Name of Individual	D.O.B			Date of Assessment
	Circle which is appropriate.			**Suggested outcome/actions.**
1. Does the individual have any of their natural teeth?	No	Yes	Don't know	Encourage independence with cleaning teeth morning and night. Use a small-headed toothbrush and fluoride toothpaste.
2. Does the individual wear dentures?	No	Yes	Don't know	Supervise/help with cleaning dentures morning and night with unperfumed soap and water; rinse dentures after meals. Gently clean the oral mucosa with moist gauze. Leave dentures out overnight if acceptable to resident and soak in water with sodium hypochlorite.
Specify:		Upper Lower		
(a) If YES, how old are dentures?	Less than 5 years	More than 5 years	Don't know	Consider referral to dentist for replacement of old dentures.
3. Does the individual need help to clean teeth/dentures?	No	Yes		May need supervision/help with mouth care.
4. Does the individual complain of suffering any oral problems? Please tick: Facial swelling ☐ Painful natural teeth ☐ Non-healing ulcers ☐ Decayed/broken teeth ☐ Bleeding gums ☐ Lost dentures ☐ Denture problems ☐	No	Yes to any		Discuss with individual/family and if in agreement, complete a referral or make an appointment for individual to see a dentist.
5. Date of last dental treatment:	Less than 2 years ago	More than 2 years ago	Don't know	Consider referral to dentist for check up if the individual wishes.
6. Registered for dental care?	No	Yes	Don't know	Consider referral to dentist for check-up if the individual wishes.
If YES, record name and address of dentist				
7. Is the individual taking medication?	No	Yes		Consider drugs which may have oral side-effects. Check with pharmacist.
8. Does the individual complain of a dry mouth?	No	Yes		Clean lips and oral soft tissues with a water-moistened gauze and protect with water-based gel. Offer frequent fluids and/or iced water. If symptoms persistent, refer to dentist.
9. Does the individual smoke?	No	Yes		Note amount per day. Consider smoking cessation.
If further investigation required, please refer to dentist.	Referred to dentist? ☐ No ☐ Yes Advice from dentist? ☐ No ☐ Yes Individual refused referral? ☐ Yes			

Signed_____ Date_____

Adapted from: Fiske, J., Griffiths, J., Jamieson, R., Manger, D. and British Society For Disability And Oral Health Working,Group, 2000. Guidelines for oral health care for long-stay patients and residents. *Gerodontology*, 17(1), 55-64.