Locala Community Partnerships

Resident Admission, Initial Assessment for Oral Care

Resident's Name ________________________ Date of admission _______________

Date of Assessment _____________________ Assessed by ____________________

- Whenever possible discuss with resident / relatives. Oral hygiene for people reliant on others for care causes great concern for resident / relatives, when this is not adequately carried out.

1) Does the resident have natural teeth? Yes ☐ No ☐

2) Does the resident have partial or full dentures? Yes ☐ No ☐ Upper ☐ Lower ☐

a) Do you feel denture marking would be helpful? Yes ☐ No ☐

3) Does the patient have any Crown or Bridgework? Yes ☐ No ☐ Don't know ☐

4) Are there any specific problems in or around the mouth area? Yes ☐ No ☐

E.g. Pain ☐ Difficulty eating ☐ Dry mouth ☐ Ulcers ☐ Bad breath ☐ Loose teeth ☐

If yes give a description and arrange a dental appointment if necessary.

____

5) Is the resident able to carry out own oral care? Yes ☐ No ☐ With support ☐

6) Is the resident a smoker? Yes ☐ No ☐ Don't know ☐

7) Does the resident have a regular Dentist? Yes ☐ No ☐

If yes,

Name of Dental Practitioner ____

Tick the list blow to ensure that the resident has the following oral aids (tools)

Toothbrush ☐ Toothpaste ☐ Denture pot ☐

Dentures marked with identification ☐

Include additional support if appropriate e.g. Toothbrush handle adaptor, mouth moisturiser

Caring for you, locally