MOUTH CHECKLIST

Please answer the questions, tick any relevant answers or add comments in the boxes provided
To be used by home care managers

Client Name:

Name of person completing this form:

Date of completion:

Dentist's name & contact no.: ○ Don't know

Note: If there is no dentist and the person would like to go to a dentist, their carer or family member can contact

.....

The person's mouth care:

01. When was the last time the person saw the dentist? ○ Less than 24 months ○ More than 24 months

02. Is the client experiencing any problems with their mouth?

○ Pain ○ Difficulty eating ○ Teeth that have changed colour/wobbly/have holes ○ Dry mouth ○ Gums that bleed
○ Wounds/ulcers in the mouth ○ Red or White patches ○ Bad breath ○ Lumps ○ Don't know ○ Other:

03. Do the person's teeth seem to be sensitive to cold or hot foods/drinks? ○ Yes ○ No

04. Does anyone need to do anything about making an appointment with the dentist? ○ Yes ○ No

Name of the person doing this: .....

05. Does the person have: ○ Natural Teeth? ○ Dentures? ○ Crowns?

06. Does the person: ○ Smoke? ○ Drink more than 2-3 units of alcohol per day? ○ Drink sugary/fizzy drinks?

07. Does the person take any medication that may affect the mouth? ○ Yes ○ No

E.g. sugary liquids, syrups (e.g. Lactulose etc.)

08. When brushing, is the person: ○ Completely independent ○ Requiring some help ○ Unable to brush alone

If needed, are they happy to let someone else provide care for their mouth and teeth? ○ Yes ○ No

09. Is the person left or right handed? ○ Left handed ○ Right handed

10. Does the person need their head supported for mouth care? ○ Yes ○ No

Comments:

Brushing Teeth:

11. If the person has dentures:

How are they cleaned and by whom? .....

Where are they stored when out of the mouth? .....

Is their name on them in case they go into hospital? .....

12. How often does the person brush their teeth in a day? .....

13. What time does the person prefer to brush their teeth? ○ Before of after breakfast ○ Before bed ○ Other

Note: It is recommended that we brush last thing in the night and at least one other time each day.

14. Where is the most comfortable place for the person to brush their teeth? .....

(E.g. in their bedroom / in the bathroom / in the bath / sitting / standing)

Comments:

Toothbrush

15. What type of toothbrush does the person use? (E.g. Manual or Electric? What colour? What size?)

.....

Who gets the toothbrush if it needs replacing? .....

16. Has it been adapted so it is easier to hold? ◯ Yes ◯ No

Comments:

Toothpaste

17. What type of toothpaste does the person use?

(E.g. normal, low foaming, unflavoured, Sodium Laundry Sulphate (SLS) Free)

.....

Has the person had high flouride toothpaste prescribed by a dentist? ◯ Yes ◯ No

Who gets the toothpaste if it needs replacing? .....

Note: Fluoride toothpaste (1350-1500ppm fluoride) is recommended for everyone.

Comments:

Other oral health aids

18. Does the person use additional oral health products?

(E.g. mouth prop, interdental brush or products for dry mouth)

Who gets these aids if they need replacing? .....

Comments:

Reporting

19. Does the care plan need reviewing/updating to include dental care? ◯ Yes ◯ No

20. Do relevant forms (E.g. ambulance transfer forms etc.) need updating? ◯ Yes ◯ No

Comments:

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