

Oral Health Assessment Tool

Resident: _____ Completed by: _____ Date: _____

Resident: is independent needs reminding needs supervision needs full assistance

- Will not open mouth Grinding or chewing Head faces down Refuses treatment
 Is aggressive Bites Excessive head movement Cannot swallow well
 Cannot rinse and spit Will not take dentures out at night

Healthy	Changes	Unhealthy	Dental Referral	Healthy	Changes	Unhealthy	Dental Referral
Lips				Natural Teeth			
<input type="checkbox"/> Smooth, pink, moist	<input type="checkbox"/> Dry, chapped or red at corners	<input type="checkbox"/> Swelling or lump, red/white/ulcerated bleeding/ulcerated at corners *	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No decayed or broken teeth or roots	<input type="checkbox"/> 1-3 decayed or broken teeth/roots, or teeth very worn down	<input type="checkbox"/> 4 or more decayed or broken teeth/roots or fewer than 4 teeth, or very worn down teeth *	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tongue				Dentures			
<input type="checkbox"/> Normal moist, roughness, pink	<input type="checkbox"/> Patchy, fissured, red, coated	<input type="checkbox"/> Patch that is red and/or white/ulcerated, swollen *	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No broken areas or teeth, worn regularly, and named	<input type="checkbox"/> 1 broken area or tooth, or worn 1-2 hours per day only or not named	<input type="checkbox"/> 1 or more broken areas or teeth, denture missing /not worn, need adhesive, or not named *	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gums and Oral Tissue				Oral Cleanliness			
<input type="checkbox"/> Moist, pink, smooth, no bleeding	<input type="checkbox"/> Dry, shiny, rough, red, swollen, sore, one ulcer/sore spot, sore under dentures	<input type="checkbox"/> Swollen, bleeding, ulcers, white/red patches, generalised redness under dentures *	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Clean and no food particles or tartar in mouth or on dentures	<input type="checkbox"/> Food, tartar, plaque 1-2 areas of mouth, or on small area of dentures	<input type="checkbox"/> Food particles, tartar, plaque most areas of mouth, or on most of dentures *	<input type="checkbox"/> Yes <input type="checkbox"/> No
Saliva				Dental Pain			
<input type="checkbox"/> Moist tissues watery and free flowing	<input type="checkbox"/> Dry, sticky tissues, little saliva present, resident thinks they have a dry mouth	<input type="checkbox"/> Tissues parched and red, very little/no saliva present, saliva is thick, resident thinks they have a dry mouth *	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> No behavioural, verbal or physical signs of dental pain	<input type="checkbox"/> Verbal &/or behavioural signs of pain such as pulling at face, chewing lips, not eating, changed behaviour.	<input type="checkbox"/> Physical pain signs (swelling of cheek or gum, broken teeth, ulcers), as well as verbal &/or behavioural signs (pulling at face, not eating, changed behaviour) *	<input type="checkbox"/> Yes <input type="checkbox"/> No

* Unhealthy signs usually indicate referral to a dentist is necessary

Assessor Comments