

**CENTRAL STATE HOSPITAL
DENTAL ASSESSMENT**

A. DENTAL STATUS

- | | | | | |
|----------------------|-----------------------------------|--|--|---|
| Pain Survey | <input type="checkbox"/> Negative | <input type="checkbox"/> Client reports oral pain | <input type="checkbox"/> Client behaviors indicative of pain | <input type="checkbox"/> Other |
| Soft Tissue: | <input type="checkbox"/> WNL | <input type="checkbox"/> Ulceration(s) | <input type="checkbox"/> White lesion(s) | <input type="checkbox"/> Red lesion(s) <input type="checkbox"/> Other |
| Gums: | <input type="checkbox"/> WNL | <input type="checkbox"/> Gingivitis | <input type="checkbox"/> Hyperplasia | <input type="checkbox"/> Pocketing <input type="checkbox"/> Other |
| Dentition: | <input type="checkbox"/> Full | <input type="checkbox"/> Partial | <input type="checkbox"/> Mixed | <input type="checkbox"/> Edentulous |
| Teeth: | <input type="checkbox"/> WNL | <input type="checkbox"/> N/A (edentulous) | | |
| | | <input type="checkbox"/> Cavity(s) | <input type="checkbox"/> Chipped tooth(s) | <input type="checkbox"/> Attrition <input type="checkbox"/> Other |
| Periodontia: | <input type="checkbox"/> WNL | <input type="checkbox"/> N/A (edentulous) | <input type="checkbox"/> Tooth Mobility | |
| | | <input type="checkbox"/> Early Periodontitis | <input type="checkbox"/> Moderate Periodontitis | <input type="checkbox"/> Advanced Periodontitis |
| X-ray Survey: | <input type="checkbox"/> Complete | <input type="checkbox"/> Client unable to tolerate | <input type="checkbox"/> Client refuses x-rays | <input type="checkbox"/> ↓ Dx quality due to movement |
| Oral Hygiene: | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | |
| Cooperation: | <input type="checkbox"/> Good | <input type="checkbox"/> Fair | <input type="checkbox"/> Poor | |

Additional findings or comments: _____

B. DENTAL HISTORY

- Client presents with medical and/or behavioral conditions compromising certain diagnostic and treatment interventions:

- Client has required medical immobilization and/or anti-anxiety medication/minimal sedation in the past
 Other _____

C. ORAL CARE PLAN

- Regular examinations
 Periodontal maintenance/prophylaxis recall
 Return to dental clinic for treatment/follow-up: _____

Special Considerations:

- Anti-anxiety medication/minimal sedation maybe necessary to ↓ anxiety and hazardous client movement (CSH Policy 4.54)
 Medical immobilization may be necessary to minimize hazardous client movement (CSH Policy 4.49)
 Antibiotic coverage will be necessary for invasive procedures (American Heart Association recommendations)
 Emergency dental treatment Only requiring Physician Medical Clearance

D. RECOMMENDATIONS FOR CLIENT AND LIVING AREA STAFF

- Oral hygiene care has been good. Keep up the good work.
 More encouragement and/or assistance with daily oral hygiene tasks.
 More encouragement to comply with treatment recommendations.
 Other _____

Stamp Plate

 Dentist Signature Provider Number Date