CARE HOME NAME:		
ORAL HEALTH CARE PLAN FOR:		**GENDER: M /F /not given**
D.O.B.		**ETHNICITY:**
1. Current Dentist		**COMMENTS**
NAME AND CONTACT DETAILS OF REGULAR DENTIST, including tel no. (please state if no dentist)		
Date of last appt (or state unknown):		
Date of next appointment or comment if to be arranged:		
IF REFERRED PLEASE ADD FURTHER COMMENTS (or n/a)	Referred to DCLP/local dentist/special care/domiciliary Additional comments:	
If REFUSES TO SEE A DENTIST	COMMENTS FROM Oral Health Champion OR Dental Champion:	
2. Access and dependency		
Did resident have capacity to agree to OH risk assessment?	Y/N/not sure	
Behavioural issues which would impact on a dental visit?	Add comments or n/a:	
Support required if resident cannot mobilise independently?	Wheelchair access/carer support/arrange transport/domiciliary care/ other/n/a	
NHS dental payment status and exemption details if applicable (comment if requires to be verified):		
3. General Health (or attach as additional sheets)		
Relevant medical history? Medication list		
4. Immediate Oral Health	**Cross if updated care plan present** ☐	**Cross if daily log present** ☐
Details of any urgent dental issues? (or comment n/a)		
Comments only if outstanding actions on daily log or n/a		
5. Dentures - only if applicable. If not applicable, please cross here and continue to section 6 ☐		
Does resident need help to place dentures in and out	Y / N	
Identified dentures need marking	Date completed or n/a	
Identified denture pot needed	Date provided or n/a	
6. Mouth care		
Resident has natural teeth?	Y/N	
Toothbrush/mouthcare type used:	e.g. manual/electric/special toothbrush or swab	
Does it need replacing	Y / N	If yes date replaced:
Usual toothpaste brand name (or n/a):		
OHC/DC comments if concerned may need high fluoride toothpaste prescription (or n/a)		
Other oral cleaning methods or n/a		
Preferred time and place for oral care	Am:	PM:
Who provides mouthcare products		

Support needed for oral care (delete as applicable):	No ASSISTANCE (GREEN)	SOME ASSISTANCE (AMBER)	FULL ASSISTANCE (RED)
7. **Diet**			
Diet advice provided			
8. Evaluation Question			
Answer to following question: I feel my daily oral care routine is supported by the care home (delete as applicable)	Strongly disagree / disagree / neither disagree or agree / agree / strongly agree / don't know		
Review date and comments - 6 monthly or sooner if changes are identified to oral health care plan. A new risk assessment and oral care plan may be required.			
Date of review:			
Comments			
Date of review:			
Comments			
Date of review:			
Comments			
Date of review:			
Comments			