ASSESSMENT OF CURRENT ORAL HYGIENE CARE

LONG TERM CARE
ORAL HEALTH PROGRAM

HOME: ______________________________

Date: ______________________________

Resident's name: ____ Room #: __________________

Current oral status (check one or both, and check appropriate description):

Resident has natural teeth: ❑ Upper ❑ Lower
Resident has removable denture: ❑ Upper ❑ Lower
❑ Resident **DOES** wear denture(s)
❑ Resident **DOES NOT** wear denture(s)

Self-care ability (check one):

❑ Can do oral hygiene alone and without reminding
❑ Needs reminding to do own oral hygiene
❑ Remembers to do, but needs assistance
❑ Needs reminding and assistance to complete oral hygiene
❑ Needs all oral hygiene to be done by provider
❑ Needs palliative oral hygiene care

Brushing aids and frequency (natural teeth):

❑ Soft toothbrush _____ x/day ❑ Electric toothbrush _____ x/day
❑ Adapted toothbrush _____ x/day ❑ Other ________________________ x/day

Flossing (check one): ❑ Yes ❑ No

Denture care (if applicable):

❑ Denture cleaner (paste) ___ x/day
❑ Denture solution (tablets) ___ x/day
❑ Denture brush ____x/day

Mouth rinses:

❑ Fluoride ❑ Mouthwash: ___________________________ ❑ Warm salt water
Name

Saliva stimulant:

❑ Artificial saliva ❑ Sialagogue pill ❑ Sugar-free gum ❑ Other ________________________

Challenges with daily care for resident:

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