

Remote oral health check-in form

Name:			
Date of birth: (dd/mm/yyyy)			
Accompanied by:			
Name:	Job title:		
Pre-ROHC Documents Reviewed:	Medical History Form	Pre-ROHC Questionnaire	
	Mouth Check	Completed Consent Form	
Start time:	End time:		

Questions	Details
Please state the relevant medical history findings which affect provision of oral care: e.g. learning disability/ autism/ dysphagia	Details:
Is the child/ young person dependent on support for daily mouth care?	Yes No If yes: Partially dependent Details:
Does the child/ young person have a specialised diet with input from a dietician?	Yes No Details:
What findings were found on examination?	Extra-oral findings:
	Intra-oral findings:



Qualitative assessment of co-operation of child?	Excellent Good Fair Difficult but managed Extremely difficult Details:
Are additional communication tools required? e.g. British Sign Language, Makaton, PECS	Yes No Details:
Dental risk rating?	Red (high risk) Amber (medium risk) Green (low risk) Details:
From the risk rating above, what remote oral health check-in recall period has been suggested?	Details:
Is a face-to-face appointment required?	Yes No If no, why?
If yes, what are the reasons for a face-to-face appointment/ when should this be/ what will be required	Details:
If yes, which dental setting should the child/ young person be seen in? (please refer to 'Planning care following the Remote Oral Health check-in' resource for assistance)	General Dental Services Community Dental Services Hospital Dental Services Not applicable
Please list any reasonable adjustments required e.g. wheelchair access, bariatric chair, time of day appropriate for visit etc	Details:
Following today's remote oral health check- in, does this child/young person have a mouth care plan in place?	Yes No Details:
	If no, why?

Please ensure the child/young person's tailored mouth care plan includes information on the following:	Time of toothbrushing:		
	AM	PM	Another time of day:
	Location of toothbrushing:		
	Toothbrush:		Toothpaste:
	Dietary Advice: (if dietician invol	ved, please ensure cc'd into mouth care plan)
	Any additional d	etails: (e.g. dry r	mouth care)
Outcome: (please tick all which apply)	Onward re		check-in at a specified recall period: