NHS England

Mouth check for: ....

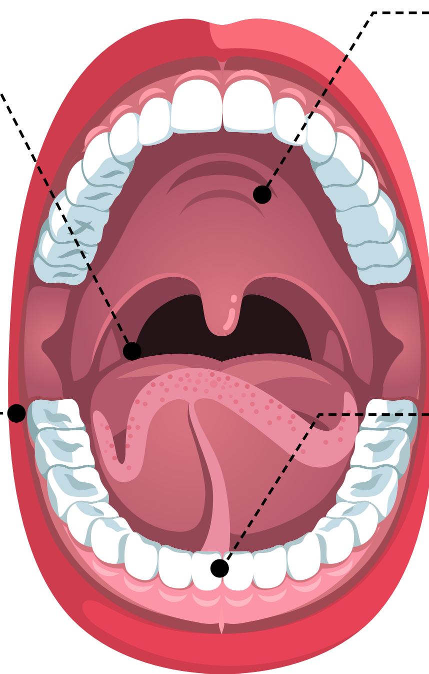
Date of Birth: .... **Today's Date:** ....

Any medical conditions/ disability which can affect mouth care:	**Any obvious dental problems e.g. facial swelling/ falls causing broken teeth?** Yes No	**Any changes to eating/ sleeping/ behaviour?** Yes No	**If yes please specify**

Please lift the lip and check all areas of the mouth. Tick what applies and record any concerns in the box beneath each section:

Saliva:

- (G) Mouth moist, visible saliva
- (A) Visibly dry mouth
- (R) Thick, stringy saliva



Lips, tongue and soft tissues (inside of cheeks, roof of mouth, underneath tongue):

- (G) Smooth, moist, clean
- (A) Dry, cracked, coated
- (R) Sore, ulcerated

Gums:

- (G) Firm gums, no bleeding
- (A) Some bleeding on brushing, slightly inflamed
- (R) Puffy and inflamed gums, lots of bleeding on brushing or gum swelling present, bad breath

Teeth:

- (G) Clean teeth, little to no plaque
- (A) Some plaque and tartar present
- (R) Decayed or broken teeth, very wobbly or loose teeth (not including baby teeth)

Mouth Check Completed Yes No

If no, please give reason

Mouth Check Result

If all **GREEN (G)**: continue regular mouth care plan

If any **AMBER (A)**: refer to mouth care guide for actions to follow

If any **RED (R)**: inform senior to consider referral to dentist

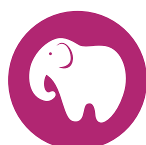
Mouth check completed by:

Name: ....

Signature ....

Job Title: ....

Next mouth check due: ....



Mini Mouth Care Matters