ORAL HEALTH ASSESSMENT TOOL (OHAT) for NON-DENTAL PROFESSIONALS

Primary Care

Patient/Client:

Date:

Initial assessment ○ **Repeat assessment** ○ **1** ○ **2** ○

*NOTE: A Star * and underline indicates referral to an oral health professional (i.e. dentist, dental hygienist, denturist) is required.*

Category	0 = healthy	1 = changes	2 = unhealthy	Score	Action Required	Action Completed
Lips	Smooth, pink, moist	Dry, chapped, or red at corners	Swelling or lump, white/red/ulcerated patch; bleeding/ ulcerated at corners*		1=intervention 2 =refer	☐YES ☐ NO
Tongue	Normal, moist, pink	Patchy, fissured, red, coated	Patch that is red and/or white, ulcerated, swollen*		1=intervention 2 =refer	☐YES ☐ NO
Gums and Tissues	Pink, moist, Smooth, no bleeding	Dry, shiny, rough, red, swollen around 1 to 6 teeth, one ulcer or sore spot under denture*	Swollen, bleeding around 7 teeth or more, loose teeth, ulcers and/or white patches, generalized redness and/or tenderness*		1 or 2 = refer	☐YES ☐ NO
Saliva	Moist tissues, watery and free flowing saliva	Dry, sticky tissues, little saliva present, resident thinks they have dry mouth	Tissues parched and red, very little or no saliva present; saliva is thick, ropey, resident complains of dry mouth*		1=intervention 2 =refer	☐YES ☐ NO
Natural Teeth ☐ Y ☐ N	No decayed or broken teeth/ roots	1 to 3 decayed or broken teeth/roots*	4 or more decayed or broken teeth/ roots, or very worn down teeth, or less than 4 teeth with no denture*		1 or 2 = refer	☐YES ☐ NO
Denture(s) ☐ Y ☐ N	No broken areas/ teeth, dentures worn regularly, name is on	1 broken area/tooth, or dentures only worn for 1-2h daily, or no name on denture(s)	More than 1 broken area/tooth, denture missing or not worn due to poor fit, or worn only with denture adhesive*		1 = ID denture 2 = refer	☐YES ☐ NO
Oral Cleanliness	Clean and no food particles or tartar on teeth or dentures	Food particles/ tartar/ debris in 1 or 2 areas of the mouth or on small area of dentures; occasional bad breath	Food particles, tartar, debris in most areas of the mouth or on most areas of denture(s), or severe halitosis (bad breath)*		1=intervention 2 =refer	☐YES ☐ NO
Dental Pain	No behavioural, verbal or physical signs of pain	Verbal and/or behavioural signs of pain such as pulling of face, chewing lips, not eating, aggression*	Physical signs such as swelling of cheek or gum, broken teeth, ulcers, 'gum boil', as well as verbal and or behavioural signs*		1 or 2 = refer	☐YES ☐ NO
				Completed by:		

REFERRAL ☐ Referral to oral health professional Date _____ Name _____

INTERVENTIONS ☐ Chronic disease management ☐ Acute illness management ☐ Medication review ☐ Patient/Client/Family education

☐ Referral to health professional ☐ MD ☐ Nurse/NP ☐ Dietician ☐ OT ☐ SW ☐ Community worker ☐ Other _____

NOTES:

2008 September ***modified with permission from Dr. Chalmers***

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