

**ORAL HYGIENE MANAGEMENT PLAN**
**Client Name:**
**Client Date of Birth:**
**Dentist Details**

Dental Practice Name

Phone number

Type of Practice

Public/Private

List all dental appointments:

Date of next OHCP review:

Does the client wish staff to assist with oral hygiene care problems

 Yes  No

IS this assessment

 Baseline

 3 month

 6 month

**Dentures**

Upper

 Full  Partial  Not worn  No denture  Named

Lower

 Full  Partial  Not worn  No denture  Named

Denture cleaning

 Daily  When possible

Best time to clean dentures

**Natural teeth**

Upper

 Yes  No  Roots present

Lower

 Yes  No  Roots present  Attempt denture

Cleaning

 Daily  When possible

Best time to clean teeth

**Interventions for oral hygiene care Please tick all that apply**

- |                          |   |                          |                                 |
|--------------------------|---|--------------------------|---------------------------------|
| <input type="checkbox"/> | Is independent – no assistance needed           | <input type="checkbox"/> | Forgets to do oral hygiene care |
| <input type="checkbox"/> | Needs reminding/prompting/task breakdown        | <input type="checkbox"/> | Won't open mouth                |
| <input type="checkbox"/> | Needs supervision/checking of oral hygiene      | <input type="checkbox"/> | Refuses oral hygiene care       |
| <input type="checkbox"/> | Needs full assistance from staff                | <input type="checkbox"/> | Does not understand             |
| <input type="checkbox"/> | Uses bridging/chaining/distraction techniques   | <input type="checkbox"/> | Is aggressive/kicks/hits        |
| <input type="checkbox"/> | Use electric/suction toothbrush                 | <input type="checkbox"/> | Can't swallow properly          |
| <input type="checkbox"/> | Use backward bent toothbrush for access         | <input type="checkbox"/> | Can't rinse and spit            |
| <input type="checkbox"/> | Use bite block                                  | <input type="checkbox"/> | Bites toothbrush and/or staff   |
| <input type="checkbox"/> | Use chlorhexidine spray bottle/gel daily weekly | <input type="checkbox"/> | Constantly grinding/chewing     |
| <input type="checkbox"/> | Use fluoride                                    | <input type="checkbox"/> | Head faces downwards            |
| <input type="checkbox"/> | Use Neutraflour 5000 toothpaste                 | <input type="checkbox"/> | Other                           |
| <input type="checkbox"/> | Use oral balance gel for dry mouth              |                          |                                 |

**Assessment Completion**

Name of person completing the assessment:

Designation:

Date and time assessment completed:

Signature:

Date uploaded to iCare: