Alzheimer's QUEENSLAND

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