AQ@HOME

ORAL HYGIENE MANAGEMENT PLAN

Client Name:	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 Neutrafluor 5000 toothpaste	☐	Other
☐	Use oral balance gel for dry mouth		

Assessment Completion
Name of person completing assessment:
Designation:
Date and time assessment completed:
Signature:
Dae uploaded to VisualCare: