

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

Primary Care

Patient/Client: _____

Initial assessment Repeat assessment 1 2

Date: _____

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