

Name:

Age/Race/Gender:

Last four digit of NRIC/FIN or ID no.:

Other details (contact/address):

**DENTAL HX:**  
C/O

OH routine/items:

F/U

Diet:

LA/CS/GA

Dysphagia

**E/O:**

**I/O:**

- OH [good / fair/ poor / v poor]
- Perio: H I B A C A M\*
- ST:
- HT:
- Dentures [type/condition/replace]:

\* Halitosis, Inflammation visibly, Bleeding visibly, Acute/abscess signs, Calculus, Attachment loss, Mobility II+

**MEDICAL HISTORY / MEDICATIONS**

(anti-resorptive / anti-thrombotic)

Allergies:

**SOCIAL HX:**

Living/Work:

NOK/CAD/LPA

Disabilities:

[ ] Mental Capacity

Bv / Cx / Cz / Gx

Amb / Supp / WC self/ WC Trf / Bed / Tpt

Smoke/Alcohol/Drug:

**BDA Case Mix (see form)**

- Communication
- Cooperation
- Medical status
- Oral risk
- Access
- Legal ethical

Tx Req																
Perio (Mob)																
	8	7	6	5	4	3	2	1	1	2	3	4	5	6	7	8
Perio (Mob)																
Tx Req																

Buccal  
 Palatal  
 Lingual  
 Buccal

BPE		
Salv pH		

Treatment received:

Additional notes:

<p><b>Referral [ ]:</b>                  Specialist centres / Polyclinics / General dentists / Nil  <i>Dear Colleague, this individual may require dental care for:</i></p> <p style="text-align: right;"><i>Thank you!</i></p>	<p><b>Screened by:</b></p> <p><b>Assisted by:</b></p> <p><b>Date:</b></p>	<p><b>BDA:</b></p> <p><b>DMFT:</b></p> <p><b>DMFS:</b></p> <p><b>Perio:</b></p> <p><b>Teeth left:</b></p>
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