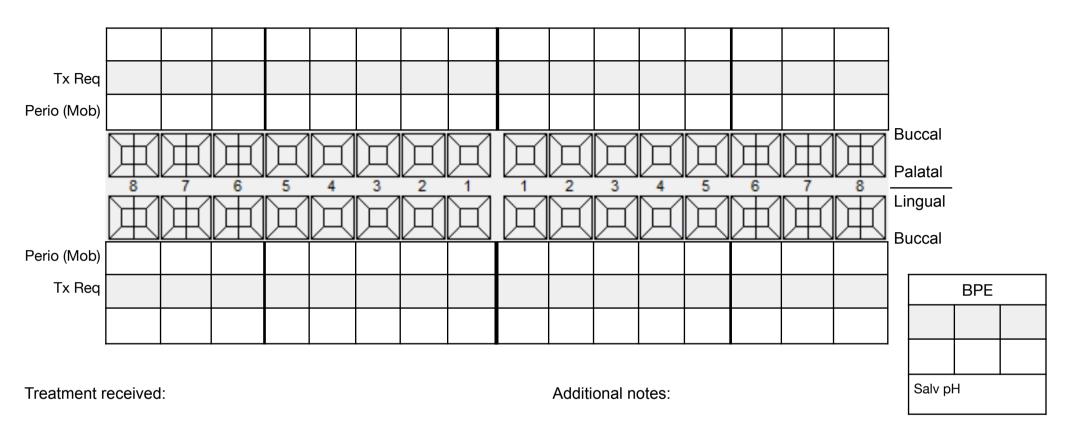
oral Health Screening Form	
Name:	
Age/Race/Gender:	
Last four digit of NRIC/FIN or ID no.:	
Other details (contact/address):	
DENTAL HX : C/O	
OH routine/items:	
F/U	
LA/CS/GA Diet:	
Dysphagia	
E/O:	
 I/O: OH [good / fair/ poor / v poor] Perio: H I B A C A M* ST: 	
• HT:	
Dentures [type/condition/replace]:	
* Halitosis, Inflammation visibly, Bleeding visibly, Acute/abscess signs, Calculus, Attachment loss, Mobility II+	

MEDICAL HISTORY / MEI	DICATIONS	
(anti-resorptive / anti-thron Allergies:	nbotic)	
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		
	D 7:10 D 1:	



Referral []:	Screened by:	BDA:
Specialist centres / Polyclinics / General dentists / Nil Dear Colleague, this individual may require dental care for:		DMFT:
	Assisted by:	DMFS:
		Perio:
		Teeth left:
	Date:	
Thank you!		