ORAL ASSESSMENT TOOL

PATIENT NAME **ADMISSION #** **DATE**

ORAL CAVITY

TEETH

DENTURES ☐ UPPER ☐ LOWER
PARTIAL ☐ UPPER ☐ LOWER

☐ MISSING ☐ CARIOUS/BROKEN ☐ NO TEETH

APPEARANCE

LIPS

☐ NORMAL ☐ DRY,CHAPPED ☐ WHITE/RED PATCHES
☐ BLEEDING ☐ ULCERS ☐ OTHER _____

TONGUE

☐ NORMAL/COATED ☐ WHITE/RED PATCHES ☐ OTHER _____

GUMS

☐ NORMAL ☐ SWOLLEN ☐ BLEEDING ☐ FISSURED ☐ OTHER

CHEEK, FLOOR, AND ROOF OF MOUTH

☐ NORMAL ☐ DRY ☐ RED ☐ SWOLLEN
☐ WHITE/RED PATCHES ☐ OPEN SORES ☐ OTHER _____

ODOR NOTED ☐ YES ☐ NO

DEBRIS NOTED ☐ YES ☐ NO

FUNCTION

RESIDENT ABILITY TO EAT WITH FULL/PARTIAL DENTURES
☐ GOOD ☐ FAIR ☐ POOR ☐ NA

RESIDENT REQUIRES ASSISTANCE WITH ORAL CARE ☐ YES ☐ NO
If yes, describe _____

RESIDENT REQUIRES TOTAL ORAL CARE ☐ YES ☐ NO

DENTAL REFERRAL RECOMMENDED ☐ YES ☐ NO

NURSE PERFORMING ASSESSMENT _____