ORAL ASSESSMENT TOOL

PATIENT NAME

ADMISSION #

DATE

ORAL CAVITY

TEETH

DENTURES

PARTIAL

□ UPPER

□ LOWER

□ UPPER

□ LOWER

□ MISSING

□ CARIOUS/BROKEN

□ NO TEETH

APPEARANCE

LIPS

□ NORMAL

□ DRY, CHAPPED

□ BLEEDING

□ ULCERS

□ WHITE/RED PATCHES

□ 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 ________________________________