Disability Resource Hub Disclaimer

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Family & Community Services
Ageing, Disability & Home Care

My oral health plan

My name:

Insert photo

Date of plan	
CIS number	
Person responsible	

My support *Completed by the person and support worker*

Do I have my natural teeth?	☐ Yes ☐ No	If no, do I have dentures?	☐ Yes ☐ No
What support do I need with my oral health?	☐ None ☐ Some help ☐ I need full support	☐ Verbal prompting ☐ Physical help ☐ Other: _____	
The place I prefer to have my teeth / mouth cleaned is:			
What is best way to communicate with me about my oral health needs?			
What special oral hygiene requirements do I have? (if any e.g. how do I use mouthwash or floss my teeth?)			

My routine *Completed by the GP and / or dentist*

I need my teeth / mouth cleaned (number of times per day and when):		
Tools I need to use:		
Toothbrush	☐ Soft and regular ☐ Electric ☐ Modified toothbrush	☐ Suction ☐ Mouth swab
Toothpaste	☐ I don't use toothpaste	☐ I use toothpaste
	Recommended product:	
Mouth wash	☐ I don't use mouthwash	☐ I use mouthwash
	When / how do I use it?	
	Recommended product:	

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My oral health plan

My name:

Floss	☐ Yes	☐ No
	When / how do I use it?	
	Recommended product:	
Dentures	☐ Yes	☐ No
	☐ Scrub with a brush	☐ Soak overnight
	Recommended product:	
I take medication that causes dry mouth		☐ Yes ☐ No
Dry mouth products	☐ Yes	☐ No
	When do I use it?	
	How do I use it?	
	Recommended product:	
Other information		

My annual review *Completed by the GP and / or dentist*

Date of the last oral health review by my GP or dentist	
Outcome of the oral health review (health professional to record or attach report)	
Date of the **next oral health review**	

Plan endorsement

Name of professional (dentist / GP)	
Signature of professional	
Date	

Team Leader signature and date	