|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Details** | | | |
| Given names |  | Date of Birth |  |
| Surname |  | Gender |  |
| Address |  | | |

*Under Victorian Privacy legislation, Special Needs Dental Team can only speak to* ***authorised*** *persons about the above patient and their dental care. If there is anyone else that you would like to have authority to talk to us on your behalf, please provide the name and contact details. If we are contacted by family members or others about your dental care, we can’t speak to them unless this authority is obtained first.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Authorised Person Details** | | | |
| Name |  | | |
| Relationship to patient |  | | |
| Address |  | | |
| Telephone |  | Fax |  |
| Email |  | | |

**Medical History**

*Please attach a copy of your current*

* *‘Health Summary’ or ‘Comprehensive Medical Assessment’ from your General Medical Practitioner*
* *medications list or drug chart including all PRN medications.*

|  |  |
| --- | --- |
| Please list any allergies or adverse drug reactions |  |
| Please provide details of any hospitalisations or surgery (date, hospital, procedure) you have had |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  | | *If yes* | | |
| Do you smoke? | Yes | No | | How many per day: | | |
| Do you drink alcohol? | Yes | No | | How much: | | |
| Do you take any recreational drugs? | Yes | No | | What kind: | | |
| Are you pregnant or breastfeeding? | Yes | No | |  | | |
| Do you have any management plans? | | | | | | |
| Advanced Care Directive | | | YES | | NO | *If yes, please forward a copy of the plan(s) with this form by mail/email/fax* |
| “Oral Care Plan” and/or “Home Oral Care Plan” | | | YES | | NO |
| Other plans  (e.g. diet, dysphagia, behaviour, epilepsy, NDIS) | | | YES | | NO |

|  |  |  |  |
| --- | --- | --- | --- |
| General Medical Practitioner Details | | | |
| Name |  | | |
| Practice name & Address |  | | |
| Telephone |  | Fax |  |
| Email |  | | |
| Name, Address and phone/fax/email of other Medical Specialists, Allied Health or Key Workers | | | |
|  | | | |

**Dental History**

|  |  |  |  |
| --- | --- | --- | --- |
| Previous Dentist Details | | | |
| Name |  | | |
| Practice name & Address |  | | |
| Telephone |  | Fax |  |
| Email |  | | |

|  |  |  |
| --- | --- | --- |
| When was your last dental visit? |  | |
| How often do you normally visit the dentist? |  | |
| Do you have a history of trauma to the head/neck/teeth? | Yes | No |
| Do you have jaw joint pain, clicking or locking? | Yes | No |
| Who brushes your teeth? |  | |
| How many times per day do you brush? |  | |
| What type of toothbrush and toothpaste do you use? |  | |
| Do you use anything to clean between your teeth? |  | |
| Is there anything else in your oral care routine (e.g. mouthwash)? |  | |

**Additional questions to help us prepare for your visit**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Can the patient understand and follow instructions? | Yes | No | Limited | | | | |
| Are any special communication strategies required? | Yes | No | *Please provide details:* | | | | |
| Do you have any sensory issues? | Yes | No | *Please provide details:* | | | | |
| Can you transfer to the dental chair without a hoist? | YES, unassisted or with physical assistance  YES, with a mobility aid *(please bring mobility aid to appointment)*  NO *(please attend appointment in wheelchair with head support)* | | | | | | |
| Do any of the following affect your ability to cooperate with dental treatment? | Swallowing difficulties  Limited mouth opening  Strong gag reflex | | | Uncontrollable lip/tongue movements  Uncontrollable body movements  Full/partial paralysis | | | |
| Have you had sedation for dental treatment in the past? | No  Unknown  Nitrous oxide | | | Oral sedation  IV sedation  General anaesthetic | | | |
| Would you like us to send pictures for a social story before the dental visit? | | | | | Yes | | No |
|  | | | | |  |  | |

|  |  |
| --- | --- |
| **For people who have difficulty cooperating due to cognitive impairment or dental phobia** | |
| Please list motivating things (e.g. stickers, iPad, praise, outing after appointment) |  |
| Please list things that will frighten you |  |
| Strategies to calm or distract you (e.g. music) |  |
| Strategies to help you focus (e.g. counting, time-timer) |  |

|  |
| --- |
| Is there anything else you would like us to know? |
|  |