

ORAL HEALTH ASSESSMENT TOOL (OHAT) for LONG TERM CARE

Resident: _____

Admission Assessment Annual Assessment Follow-up Assessment 1 2 3

Date: _____

NOTE: A Star* and underline indicates referral to an oral health professional (i.e. dentist, dental hygienist, denturist) is required

Category	0 = HEALTHY	1 = CHANGES	2 = UNHEALTHY	Score	Action Required	Action Completed
Lips	Smooth, pink, moist	Dry, chapped, or red at corners	<u>Swelling or lump, white/red/ulcerated patch; bleeding/ ulcerated at corners*</u>		1=intervention 2=refer	<input type="checkbox"/> YES <input type="checkbox"/> NO
Tongue	Normal, moist, pink	Patchy, fissured, red, coated	<u>Patch that is red and/or white, ulcerated, swollen*</u>		1=intervention 2=refer	<input type="checkbox"/> YES <input type="checkbox"/> NO
Gums & Tissues	Pink, moist, Smooth, no bleeding	<u>Dry, shiny, rough, red, swollen around 1 to 6 teeth, one ulcer or sore spot under denture*</u>	<u>Swollen, bleeding around 7 teeth or more, loose teeth, ulcers and/or white patches, generalized redness and/or tenderness*</u>		1 or 2 = refer	<input type="checkbox"/> YES <input type="checkbox"/> NO
Saliva	Moist tissues, watery and free flowing saliva	Dry, sticky tissues, little saliva present, resident thinks they have dry mouth	<u>Tissues parched and red, very little or no saliva present; saliva is thick, ropey, resident complains of dry mouth*</u>		1=intervention 2=refer	<input type="checkbox"/> YES <input type="checkbox"/> NO
Natural Teeth <input type="checkbox"/> Y <input type="checkbox"/> N	No decayed or broken teeth/roots	<u>1 to 3 decayed or broken teeth/roots*</u>	<u>4 or more decayed or broken teeth/roots, or very worn down teeth, or less than 4 teeth with no denture*</u>		1 or 2 = refer	<input type="checkbox"/> YES <input type="checkbox"/> NO
Denture(s) <input type="checkbox"/> Y <input type="checkbox"/> N	No broken areas/teeth, dentures worn regularly and labeled	1 broken area/tooth, or dentures only worn for 1 to 2 hours daily, or no name on denture(s)	<u>More than 1 broken area/tooth, denture missing or not worn due to poor fit, or worn only with denture adhesive*</u>		1=ID denture 2=refer	<input type="checkbox"/> YES <input type="checkbox"/> NO
Oral Cleanliness	Clean and no food particles or tartar on teeth or dentures	Food particles/ tartar/ debris in 1 or 2 areas of the mouth or on small area of dentures; occasional bad breath	<u>Food particles, tartar, debris in most areas of the mouth or on most areas of denture(s), or severe halitosis (bad breath)*</u>		1=intervention 2=refer	<input type="checkbox"/> YES <input type="checkbox"/> NO
Dental Pain	No behavioural, verbal or physical signs of pain	<u>Verbal and/or behavioural signs of pain such as pulling of face, chewing lips, not eating, aggression*</u>	<u>Physical signs such as swelling of cheek or gum, broken teeth, ulcers, 'gum boil', as well as verbal and or behavioural signs*</u>		1 or 2 = refer	<input type="checkbox"/> YES <input type="checkbox"/> NO
				Completed by: _____		

FOLLOW UP:
 1) Oral Hygiene Care Plan **updated** – Y N
 Date: _____
 2) OHAT to be **repeated** - in one year
 on date _____

REFERRAL:
 a) REFERRAL to an oral health professional **required** Y N
 b) REFERRAL **made** Y (appointment date: _____) N (see below)
 c) REFERRAL **refused** by resident/family/guardian Y
 Reason for refusal: _____ Signature: _____

(OHAT Tool, Chalmers 2004)

This version is based on modifications from the Halton Region's Health Department (2007)

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