

# 2a) Personal Oral Care Plan

Date: \_\_\_/\_\_\_/\_\_\_

Resident Information:	Completed by	
First Name	D.O.B	
Surname	Room	

Tick all that apply

Own teeth?	<input type="checkbox"/>	Dentures?	<input type="checkbox"/>	TOP WHOLE	<input type="checkbox"/>	TOP PARTIAL	<input type="checkbox"/>	BOTTOM WHOLE	<input type="checkbox"/>	BOTTOM PARTIAL	<input type="checkbox"/>	Specialist intervention required?	<input type="checkbox"/>
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The details on this oral care plan should be updated after every reassessment (1a Oral Health Assessment Tool) or after any dental visit.

## Preferred Oral Hygiene Products Tick all that apply

Preferred toothbrush type:

<input type="checkbox"/> manual	<input type="checkbox"/> electric	<input type="checkbox"/> three-headed	<input type="checkbox"/> adapted handle	adapted how?
Bristle type: <input type="checkbox"/> medium <input type="checkbox"/> soft				

Preferred denture adhesive:

Preferred denture cleaning method:

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Prescription/over-the-counter toothpaste?

Preferred toothpaste brand/flavour:

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Other oral hygiene products: (Tick all that apply, providing details where necessary)

<input type="checkbox"/> Interdental brushes:	
<input type="checkbox"/> Dry mouth products:	
Other:	

## Preferred Oral Hygiene Routine

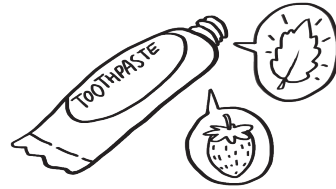
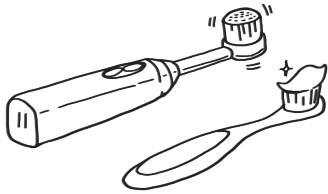
Time of day:	morning <input type="checkbox"/>	other:	
	evening <input type="checkbox"/>		
Where?:	bed <input type="checkbox"/>	Other notes (eg. effective / ineffective resistive behaviour strategies)	
	chair <input type="checkbox"/>		

## 2b) My Oral Care Plan Summary

Date: \_\_\_/\_\_\_/\_\_\_

I am: .....

and I live in room: .....



The toothbrush  
I prefer is: .....

.....  
.....

and the toothpaste  
I like is: .....

.....  
.....

Other products I need are: 1) .....

2) .....

3) .....

4) .....

I prefer to have my teeth cleaned by:

.....

because .....

I like them cleaned ..... times a day...

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> first thing in the morning | <input type="checkbox"/> before bed  |
| <input type="checkbox"/> after breakfast            | <input type="checkbox"/> other ..... |
| <input type="checkbox"/> after dinner               | .....                                |

Things that help me clean my teeth:

.....

.....

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