ORAL HEALTH CENTRE
OF WESTERN AUSTRALIA

Form 22

Caries Risk Management

Use Patient Barcode Label

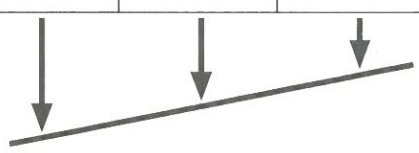
Given Name _____
Surname _____
DOB _____
TEMP _____

Assessment date_____; This is Base line or Recall (please circle)

Disease indicators (any one 'YES' signifies likely 'High Risk' and to do a bacteria test*)	**YES = Circle**	**YES = Circle**	**YES = Circle**
Visible cavities or radiographic penetration of the dentine	YES		
Radiographic approximal enamel lesions (not in dentine)	YES		
White spots on smooth surfaces	YES		
Restorations last 3 years	YES		
Risk factors (Biological predisposing factors)		YES	
MS and LB both medium or high (by culture*)		YES	
Visible heavy plaque on teeth		YES	
Frequent snack (>3 x daily between meals)		YES	
Deep pits and fissures		YES	
Recreational drug use		YES	
Inadequate saliva flow by observation or measuremnt (*if measured, note the flow rate on the opposit page)		YES	
Saliva reducing factors (medications/radiation/systemic)		YES	
Exposed roots		YES	
Orthodontic appliances		YES	
Protective factors			
Lives/work/school fluoridated community			YES
Fluoride toothpaste at least once daily			YES
Fluoride toothpaste at least 2 x daily			YES
Fluoride mouthrinse (0.05% NaF) daily			YES
5,000 ppm F fluoride toothpaste daily			YES
Fluoride varnish in last 6 months			YES
Office F topical in last 6 months			YES
Chlorhexidine prescribed/used one week each of last 6 months			YES
Xylitol gum/lozenges 4 x daily in last 6 months			YES
Calcium and phosphate paste during last 6 months			YES
Adequate saliva flow (>1 ml/min stimulated)			YES

***Bacteria test results: MS: LB: Date:**			

Visualise Caries Balance
(Use circled indicators/factors above)



Caries Risk Assessment (circle)	**Extreme**	**High**
	Moderate	**Low**

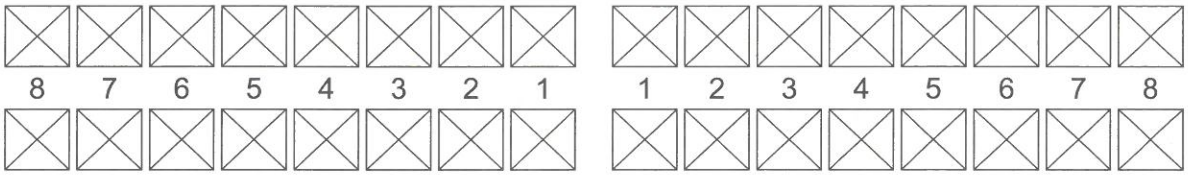
Clinician Signature:	Clinician ID:	Date:
Supervisor Signature: (If student clinician)	Supervisor ID:	

Form 22 Caries Risk Management *continuation*

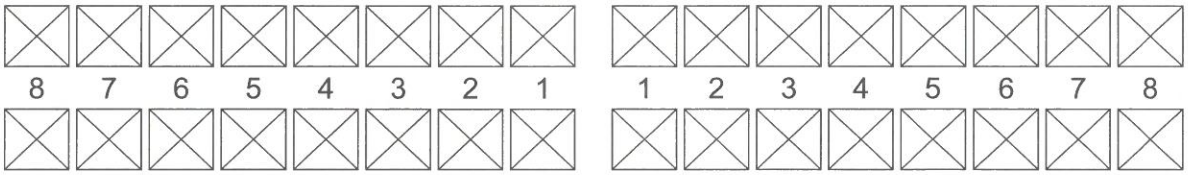
Saliva testing (item 047)

Resting saliva	Flowrate	pH	**Stimulated saliva**	Flowrate	pH
Baseline (Date:____/____/____)			Baseline (Date:____/____/____)		
Recall (Date:____/____/____)			Recall (Date:____/____/____)		
Recall (Date:____/____/____)			Recall (Date:____/____/____)		

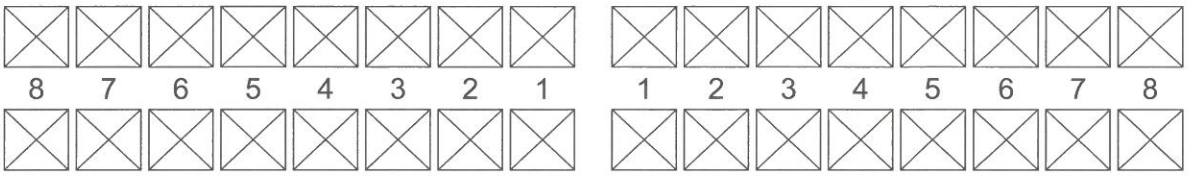
Plaque score at baseline %_____; Date_____/_____/_____



Plaque score at recall %_____; Date_____/_____/_____



Plaque score at recall %_____; Date_____/_____/_____



Caries disease management

	Disease indicators	Risk factors	Protective factors
Short term			
Medium term			
Long term			

Clinician Signature:	Clinician ID:	Date:
Supervisor Signature: (If student clinician)	Supervisor ID:	