**Your Smile Matters Screening**

**To start, some questions about the general health and appearance of your teeth and mouth:**

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| 1. What is/are your oral health goals in your own words | | | | | I rate myself on my goal | | | | | |
|  | | | | | Now | | | | Later\_\_\_\_\_Date | |
|  | | | | | Poor 1 2 3 4 5 6 7 Good | | | | Poor 1 2 3 4 5 6 7 Good | |
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| B.In general the health of my mouth/teeth is (Circle one ) 1. Poor 2. Fair 3. Good 4. Very Good 5. Excellent | | | | | | | | | | |
| C. How satisfied are you with the appearance of your teeth/dentures (Circle one) | | | 1. Very Dissatisfied 2. Dissatisfied 3. Satisfied 4. Very satisfied | | | | | | | |
| D. Do you have ? (Circle one) | 1. A full set of dentures (upper and lower jaw) 2. 2. Some of your own teeth and partial dentures or bridges 3. All your own teeth | | | | | | | | | |
| E. In the past month, have you had (Circle all that apply to you) | 1. A toothache? 2. Pain in your teeth when consuming hot or cold foods or drinks? 3. Severe tooth or mouth pain at night? 4. Pain in or around your jaw joints? 5. Bleeding gums when brushing your teeth? 6. Persistent dry mouth? 7. Persistent bad breath? 8. Discomfort when you eat food? | | | | | | | | | |
| F. I can eat/chew any foods I want (Circle One) | | | | Yes | | | | No | | |
| G. I am happy with my smile (Circle One ) | | | | Yes | | | | No | | |
| H. I have had cavities which have been filled (Circle One) | | | | Yes | | | | No | | |
| I.When was the last time that you went to a dental professional(Circle One) | 1. Less than a year ago 2. More than 1 year but less than 2 years ago 3. More than 2 years but less than 3 years ago 4. More than 3 years but less than 4 years ago 5. More than 4 years but less than 5 years ago | | | | | | 1. 5 or more years ago 2. Never 3. Don’t Know | | | |
| J.Do you usually visit a dental professional? (Circle One)  1.More that once a year for check-ups or treatment  2. About once a year for check-ups or treatment  3. Less than once a year for check-ups or treatment  4. Only for emergency care  5. Don’t know/ Refused answer | | | | | K.What reason would you not go to a dental professional?   1. Cost 2. Fear 3. Distance 4. Don’t know how to find a good one 5. Other | | | | | |
| L.Do you have insurance that covers all or part of your dental expenses (Circle One) | | | | | | Yes | | | | No |
| If yes to the above question. The insurance plan is a/an (Circle One) | | 1. Government program for social service (welfare) clients 2. Government program for children or seniors in this province or territory 3. Government program for First Nations people 4. Employer-paid plan from [my/his/her] or [my/his/her] spouse's employment 5. Retirement plan through [my/his/her] or [my/his/her] spouse’s previous employer paid for by [me/him/her] or [my/his/her] spouse 6. Other (Please, specify) | | | | | | | | |

**Screening Results\_\_\_\_\_\_\_\_Screener\_\_\_\_\_Date:**

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| 1. **Screening Results** |  | |
| 1. **Follow up Steps** 2. How to contact the person for follow up? Phone \_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Social media ( e.g. FB and What’s App)­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   1. Referral to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_( Name, Address, Phone)   Help needed for a successful referral:  \_\_\_\_\_\_Referral Information- contact the referral source to set up an appointment, negotiate fees, arrange for support  \_\_\_\_\_\_Reminder System  \_\_\_\_\_\_Accompaniment and appointment support   1. CMT Follow up\_\_\_\_Follow up clinic at CMT \_\_\_\_CMT Workshop \_\_\_\_Forms ( dentures, subsidies) \_\_\_\_­Translation \_\_\_\_Advocacy, Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   \_\_\_\_\_\_\_Interest in Healthy Living programs( List)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_Interest in Health Planner  \_\_\_\_\_\_\_Interest in other Community programs(List)­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| 1. **Follow up date** | | **Comments** |
| **Follow up date** | | **Comments** |
| **Follow up date** | | **Comments** |
| **Follow up date** | | **Comments** |
| **Community Assistant** | | |
| **Screening Date** | | |
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