

Pre-appointment triage form



Date:

Time:

Name:

Address:

Postcode:

NHS number (if known)

Name of parent or carer (if applicable)

Patient's GP Practice and Contact Number: ..

	PRE-APPOINTMENT	ON SITE
Date:		
Called previously for AAA? If so insert date and advice given here:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you been diagnosed with Coronavirus?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you having shortness of breath or other difficulties breathing?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you currently have a cough? or have you had a persistent dry cough in the last 14 days?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you experienced recent loss of taste or smell?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you in contact with any confirmed COVID-19 positive patients? Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Are you 70 years old or above?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you travelled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

Please turn over

Pre-appointment triage form cont...

Medical history (including allergies, and medication)

Presenting complaint

History of presenting complaint and/or previous treatment:

PAIN

Where is the pain coming from?

How long has pain been there?

Severity scale: 1 (no pain) - 10 (worst pain ever)

1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10

Constant pain / does it come and go?

Has it kept you awake / does it get worse at night?

SWELLING

Have you taken any painkillers? Yes No

Intraoral swelling? Size/duration

Extraoral swelling? Size/duration

Functional impairment caused by swelling (swallowing, breathing and trismus)

BLEEDING

Source, duration, amount?

Recent extractions?

Previous bleeding problems (ask about anticoagulant medications/conditions)

TRAUMA

How, Where, What, When?

Any loss of consciousness – have they visited A&E?

OTHER

Ulcers – location, size, duration?

Orthodontic appliances – is it causing soft tissue trauma?

Additional notes (including any mobility or communication needs)

Pre-appointment triage form cont...
