

# TRIAGING QUESTIONNAIRE FOR URGENT DENTAL TREATMENT

## 1. HEALTH STATUS

### COVID-19 Risk Assessment

	YES	NO
1. Do you have a confirmed diagnosis of COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you, or anyone living with you had contact with someone with a confirmed or suspected diagnosis of COVID-19?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you, or anyone living with you returned from overseas in the last 14 days?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you, or anyone living with you have the following symptoms;	<input type="checkbox"/>	<input type="checkbox"/>
- Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
- Cough	<input type="checkbox"/>	<input type="checkbox"/>
- Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
- High temperature (38°C)	<input type="checkbox"/>	<input type="checkbox"/>

### Medical Health Assessment

Please tick YES or NO beside each medical condition AND write down the drugs taken next to the condition.

	YES	NO
1. Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
2. Heart attack	<input type="checkbox"/>	<input type="checkbox"/>
3. Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
4. Open heart surgery	<input type="checkbox"/>	<input type="checkbox"/>
5. High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
6. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
7. Asthma	<input type="checkbox"/>	<input type="checkbox"/>
8. Chest & lung disease	<input type="checkbox"/>	<input type="checkbox"/>
9. Sinus/hay fever	<input type="checkbox"/>	<input type="checkbox"/>
10. Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
11. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
12. Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>
13. Gastric problems	<input type="checkbox"/>	<input type="checkbox"/>
14. Depressive illness	<input type="checkbox"/>	<input type="checkbox"/>
15. Radiotherapy/Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
16. Smoker	<input type="checkbox"/>	<input type="checkbox"/>
17. Artificial/prosthetic joint: if yes, please state when and what prothesis was placed:	<input type="checkbox"/>	<input type="checkbox"/>
18. Allergies: if yes, please state what	<input type="checkbox"/>	<input type="checkbox"/>
19. Pregnant female: if yes, please state how many weeks	<input type="checkbox"/>	<input type="checkbox"/>
20. Drugs: please list all medications --	<input type="checkbox"/>	<input type="checkbox"/>

## 2. URGENT DENTAL PROBLEM

a) **Please describe** the nature of your urgent dental problem.

b) **Photo(s):** If appropriate, please feel free to take a maximum of 2 photos to send to us following the tips below:

1. You will need to use a phone camera and the flash needs to be turned on.
2. Please follow the example below to take a total of 2 photos.
3. You will need a spoon (see example below) to hold your lips and cheeks out of the way near the affected tooth.  
(Only zoom the camera a small amount and hold the phone nice and close to the teeth, ensure the images are in focus and clear.)
4. Once you have completed all the photos, please attach the photo(s) to an email and send to your dentist with your full name and date of birth in subject line.
5. The photo may look like this >>>



- c) **Swelling** (Only fill in this section if there is swelling. Otherwise go to 4. DENTAL PAIN)

**Have you taken photos of the swelling? Please email to your dentist.**

	YES	NO
1. Is there visible swelling? When did the swelling start?	<input type="checkbox"/>	<input type="checkbox"/>
2. How has it changed since it started?	<input type="checkbox"/>	<input type="checkbox"/>
3. Can you eat/drink?	<input type="checkbox"/>	<input type="checkbox"/>
4. Is your swallowing or breathing affected?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you taking antibiotics? If yes, please state name, dose, frequency, and since when:	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you taken photo(s) of the swelling? Please email to your dentist.	<input type="checkbox"/>	<input type="checkbox"/>

- d) **Dental Trauma** (please only fill in this section if you have suffered dental trauma. Otherwise go to 4. DENTAL PAIN)

**Have you taken photos of the trauma? Please email to your dentist.**

Please describe the trauma: When, what and how did it happen?

- e) **Bleeding** (please only fill this section if you have suffered dental trauma. Otherwise go to 4. DENTAL PAIN)

**If the bleeding is severe and ongoing please ring the hospital immediately for advice.**

Please describe the current bleeding problem:

## 4. DENTAL PAIN

	YES	NO
1. Is there pain? If yes, please indicate ( <i>tick next to</i> ) your level of pain, 0-10 (0 = nothing and 10 = worst pain)  <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10	<input type="checkbox"/>	<input type="checkbox"/>
2. Please describe nature of the pain: (e.g. Comes on by itself, sore only when eating, lasts for short/long time, throbbing/sharp, etc.)		
3. Have you taken medications for the pain? If yes, please list which drugs:	<input type="checkbox"/>	<input type="checkbox"/>

## 5. YOUR DETAILS

Name	(Mr / Mrs / Miss / Ms / Dr / Prof)	(Surname)	(First Names)
Address			
Email			
Telephone			
Date of birth			
Name of your GP			
Name of your dentist			
Consent	<b>I CONFIRM THAT THE INFORMATION ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.</b>  Signed by: <input type="checkbox"/> Patient <input type="checkbox"/> Parent <input type="checkbox"/> Guardian ( <i>please tick</i> ) Name _____ Date _____		