COVID-19 Pre appointment triage

Date: / / Time:

Name:

Address:

Postcode:

Name of parent or carer (if applicable)

Patient's GP Practice:

and Contact Number:

	Pre-appointment	On site at practice
Dates :	/ /	/ /
Called previously for AAA? If so insert date and advice given here:	YES ☐ NO ☐	YES ☐ NO ☐
Have you been diagnosed with Coronavirus?	YES ☐ NO ☐	YES ☐ NO ☐
Are you having shortness of breath or other difficulties breathing?	YES ☐ NO ☐	YES ☐ NO ☐
Do you currently have a cough? or have you had a persistent dry cough in the last 14 days?	YES ☐ NO ☐	YES ☐ NO ☐
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	YES ☐ NO ☐	YES ☐ NO ☐
Have you experienced recent loss of taste or smell?	YES ☐ NO ☐	YES ☐ NO ☐
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 ☐ NO ☐	YES ☐ NO ☐
Are you 70 years old or above?	YES ☐ NO ☐	YES ☐ NO ☐
Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	YES ☐ NO ☐	YES ☐ NO ☐
Have you travelled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	YES ☐ NO ☐	YES ☐ NO ☐

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

Please turn over

COVID-19 Pre appointment triage

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) YES ☐ NO ☐
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**)