Special Olympics
Special Smiles®

Healthy Athletes Screening Form

Station1: Check In

First Name: _____ Last Name: _____ HAS ID: _____

Event Date: ____/____/_____ Date of Birth (mm/dd/yyyy): ____/____/_____ Age (years): _____

Event Location (City, State/Province or Country): _____ Delegation/SO Program: _____

Gender: ◯ Female ◯ Male ◯ Prefer not to answer Athlete Status: ◯ Athlete ◯ Unified partner ◯ Other

Sport: _____ Cell Phone: _____ Number is: ◯ Athlete's ◯ Parent's/Guardian's

Providing a phone number is optional. It will be used to send a text reminder if any follow-up is recommended after screening.

Athlete Reported Medical and Dental History

Medical History	☐ Heart disease	☐ Diabetes	☐ Smoking
	☐ Epilepsy or any type of seizure disorder	☐ Rheumatoid arthritis	☐ Liver disease
	☐ Asthma, sleep apnea, COPD, emphysema	☐ Immune compromised	
	◯ None of the above	◯ I don't know	◯ Did not answer
Dental History	☐ Missing teeth	☐ Dry mouth	☐ Pain with chewing
	☐ Fake teeth that come in and out (dentures or partials)	☐ Extra saliva	☐ Changes in your bite
	☐ Dentures or partials do not fit well	☐ Bad breath	
	◯ None of the above	◯ I don't know	◯ Did not answer

Do you have a dentist you see regularly (a dental home)?

◯ I do not have a dentist I see regularly ◯ I see the dentist every 3 months ◯ I see the dentist every 6 months
◯ I see the dentist once a year ◯ I am not sure how often I see the dentist ◯ Did not answer

About how long has it been since you last visited a dentist? This includes all types of dentists, such as, orthodontists, oral surgeons, and all other dental specialists, as well as dental hygienists.

◯ ≤ 6 months ago ◯ > 6 months, but not more than a year ago ◯ More than a year ago
◯ More than 2 years ago ◯ More than 3 years ago ◯ More than 5 years ago
◯ Never have been ◯ I don't know ◯ Did not answer

Athlete Reported Oral Health Care Habits

Brushing	Performed? ◯ Never ◯ Daily ◯ Weekly	How many times? ◯ 1 ◯ 2 ◯ 3 ◯ 4 or more
Flossing	Performed? ◯ Never ◯ Daily ◯ Weekly	How many times? ◯ 1 ◯ 2 ◯ 3 ◯ 4 or more
Rinsing	Performed? ◯ Never ◯ Daily ◯ Weekly	How many times? ◯ 1 ◯ 2 ◯ 3 ◯ 4 or more
Chewing sugar-free gum	Performed? ◯ Never ◯ Daily ◯ Weekly	How many times? ◯ 1 ◯ 2 ◯ 3 ◯ 4 or more

Do you notice any of the following when cleaning your mouth (like in Oral Health Care Habits section above):

☐ Bleeding ☐ Teeth moving ☐ Pain ◯ None ◯ I don't know ◯ Did not answer

Athlete Reported Pain or Injury

How often during the last year have you had painful aching anywhere in your mouth?

◯ Very often ◯ Fairly often ◯ Occasionally ◯ Hardly ever ◯ Never ◯ I don't know ◯ Did not answer

Are you having pain today?

◯ Yes ◯ No ◯ I don't know ◯ Did not answer

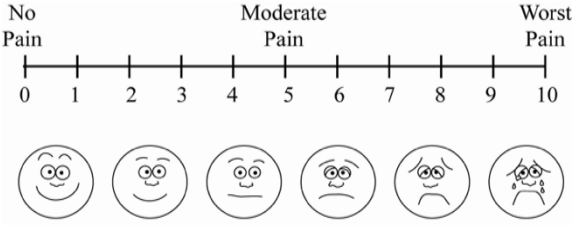
If you are having pain, where is it located?

☐ Top Front ☐ Bottom Front ☐ Back Top Right ☐ Back Top Left

☐ Back Lower Right ☐ Back Lower Left ☐ Outside of mouth/Jaw ◯ Did not answer

How would you rate your pain?

Circle a number:



◯ I don't know

◯ Did not answer

Have you experienced an injury involving your mouth in the last year?

◯ Yes ◯ No ◯ I don't know ◯ Did not answer

If yes, when did this injury occur?

(MM/YYYY): _____ ◯ I don't know ◯ Did not answer

Where in your mouth was the injury?

☐ Top Front ☐ Bottom Front ☐ Back Top Right ☐ Back Top Left ☐ Back Lower Right

☐ Back Lower Left ☐ Outside of mouth

How were you injured?

☐ Unsure ☐ Fall ☐ Sport/Leisure ☐ Other: _____

Station 2: Screening

Screener's Name:

Oral Cancer

Is a follow-up intraoral cancer screening indicated?

◯ Yes ◯ No ◯ Unable to test

If yes, localized to:

◯ Right ◯ Left ◯ Mid

Localized intraorally to:

☐ Hard Palate ☐ Soft Palate ☐ Tongue ☐ Tonsillar Area ☐ Upper Lip

☐ Lower Lip ☐ Upper Gingiva ☐ Lower Gingiva ☐ Upper Mucosa ☐ Lower Mucosa

☐ Upper Vestibule ☐ Lower Vestibule

Dental Trauma

Do you play any contact sports?

◯ Yes ◯ No ◯ I don't know ◯ Did not answer

Is there dental trauma?

◯ Yes ◯ No ◯ Unable to test

If yes, localized to:

☐ Upper Right ☐ Upper Anterior ☐ Upper Left ☐ Lower Left ☐ Lower Anterior

☐ Lower Right ☐ None of the above

Localized intraorally to:

☐ Hard Palate ☐ Soft Palate ☐ Tongue ☐ Tonsillar Area ☐ Upper Lip

☐ Lower Lip ☐ Gingiva ☐ Mucosa ☐ Vestibule ☐ Dentition

Is there pain associated with trauma?

◯ Never Pain ◯ Pain that lasted ≤ 3 months ◯ Pain that lasted > 3 months

If there was pain, is that pain now resolved?

◯ Yes ◯ No ◯ Unable to test

Date of traumatic incident associated with pain referenced:

(MM/YYYY): _____ ◯ I don't know ◯ Did not answer

Has the athlete received treatment for trauma referenced?

◯ Treated ◯ In Treatment/Monitoring ◯ Not in Treatment/Needs Referral

Abscess, Exudate, Swelling, Ulceration, and Sore Spot

☐ Unable to test

☐ **Abscess or Sinus Track**

Localized to:

☐ Upper Right ☐ Lower Left
☐ Upper Anterior ☐ Lower Anterior
☐ Upper Left ☐ Lower Right

☐ **Exudate**

Localized to:

☐ Upper Right ☐ Lower Left
☐ Upper Anterior ☐ Lower Anterior
☐ Upper Left ☐ Lower Right

☐ **Swelling**

Localized to:

☐ Intra Oral ☐ Extra Oral
☐ Upper Right ☐ Lower Left
☐ Upper Anterior ☐ Lower Anterior
☐ Upper Left ☐ Lower Right

☐ **Ulceration**

Localized to:

☐ Corners of mouth
☐ Hard Palate ☐ Vestibule
☐ Upper Right ☐ Lower Left
☐ Upper Anterior ☐ Lower Anterior
☐ Upper Left ☐ Lower Right

☐ **Sore Spot**

Localized to:

☐ Corners of mouth
☐ Hard Palate ☐ Vestibule
☐ Upper Right ☐ Lower Left
☐ Upper Anterior ☐ Lower Anterior
☐ Upper Left ☐ Lower Right

Is the athlete edentulous? ◯ **Yes** ◯ **No** ***If yes, conclude screening.**

Oral Hygiene

☐ Unable to test

☐ **Plaque**

◯ Generalized ◯ Localized

Localized to:

☐ Upper Right ☐ Lower Left
☐ Upper Anterior ☐ Lower Anterior
☐ Upper Left ☐ Lower Right

☐ **Calculus**

◯ Generalized ◯ Localized

Localized to:

☐ Upper Right ☐ Lower Left
☐ Upper Anterior ☐ Lower Anterior
☐ Upper Left ☐ Lower Right

☐ **Atypical Saliva**

Description:

☐ Dry mouth ☐ Excessive saliva
☐ Bubbles ☐ Thick
☐ Ropey ☐ Cloudy/White
☐ Other

☐ **Fluorosis**

◯ Generalized ◯ Localized

Localized to:

☐ Upper Right:	◯ Moderate	◯ Severe	☐ Lower Left:	◯ Moderate	◯ Severe
☐ Upper Anterior:	◯ Moderate	◯ Severe	☐ Lower Anterior:	◯ Moderate	◯ Severe
☐ Upper Left:	◯ Moderate	◯ Severe	☐ Lower Right:	◯ Moderate	◯ Severe

Periodontal Health

☐ Unable to test

☐ **Redness (Erythema)**

◯ Generalized ◯ Localized

Localized to:

☐ Upper Right ☐ Lower Left
☐ Upper Anterior ☐ Lower Anterior
☐ Upper Left ☐ Lower Right

☐ **Inflammation/ Swelling**

◯ Generalized ◯ Localized

Localized to:

☐ Upper Right ☐ Lower Left
☐ Upper Anterior ☐ Lower Anterior
☐ Upper Left ☐ Lower Right

☐ **Crowding or Malocclusion**

◯ Generalized ◯ Localized

Localized to:

☐ Upper Right ☐ Lower Left
☐ Upper Anterior ☐ Lower Anterior
☐ Upper Left ☐ Lower Right

☐ **Tooth Mobility**

◯ Generalized ◯ Localized

Localized to:

☐ Upper Right ☐ Lower Left
☐ Upper Anterior ☐ Lower Anterior
☐ Upper Left ☐ Lower Right

Dentition

☐ Unable to test

Dentition Inventory: Decayed, Missing, Filled Teeth

Check the box before the sextant name if decayed, missing, or filled teeth were observed in that sextant

☐ Upper Right:	☐ Decayed	☐ Missing	☐ Filled	☐ Lower Left:	☐ Decayed	☐ Missing	☐ Filled
☐ Upper Anterior:	☐ Decayed	☐ Missing	☐ Filled	☐ Lower Anterior:	☐ Decayed	☐ Missing	☐ Filled
☐ Upper Left:	☐ Decayed	☐ Missing	☐ Filled	☐ Lower Right:	☐ Decayed	☐ Missing	☐ Filled

Sealants	Are sealants present? ◯ Yes ◯ No ◯ Unable to test *If yes, localized to:* ☐ Premolar(s) ☐ Molar(s) ☐ Primary Molar(s)

Over-Retained Primary Teeth	Are there over-retained primary teeth? ◯ Yes ◯ No ◯ Unable to test *If yes, localized to:* ☐ Upper Right ☐ Upper Anterior ☐ Upper Left ☐ Lower Left ☐ Lower Anterior ☐ Lower Right

Summary	
Did the athlete report pain ("fairly often," "very often," or "today") that is unresolved?	◯ Yes ◯ No
Was the Oral Cancer section and/or any section of Abscess or Sinus Track, or Exudate positive?	◯ Yes ◯ No
Has there been trauma associated with active pain and is the athlete not in treatment/monitoring with a dentist for trauma?	◯ Yes ◯ No
If any of the above are answered yes, an urgent referral is indicated.	
Positive screen for risk of gingivitis and/or periodontitis?	◯ Yes ◯ No
If yes, a non-urgent referral is indicated.	
Are there any teeth that are decayed or missing?	◯ Yes ◯ No
If yes, a non-urgent referral is indicated for decay without evidence of infection, routine follow-up care is indicated for missing teeth. *Note: If the only concern is missing teeth, and the missing teeth are restored in any capacity (removable or fixed), consider a routine referral.*	

Station Designations	
Does the athlete play contact sports?	◯ Yes ◯ No
Is fluorosis present (see Oral Hygiene section)?	◯ Yes ◯ No
Is there tooth mobility (see Periodontal Health section)?	◯ Yes ◯ No
Are there over-retained primary teeth (see Over-Retained Primary Teeth section)?	◯ Yes ◯ No
Consider station designation based on: ▪ *Mouth Guard Station: If the athlete plays a contact sport mouth guard fitting is recommend. If positive for pain and/or mobility (Summary), or if oral candidiasis or angular cheilitis are suspected, mouth guard fitting may not be feasible.* ▪ *Fluoride Varnish Station: If there is fluorosis, the athlete is under 13 years of age, and/or positive for pain and/or abscess (Summary), application of fluoride varnish may not be feasible.*	
☐ Mouth Guard Station	☐ Fluoride Varnish Station

Determination of Oral Hygiene Instruction Needs			
Consider sections "Oral Health Care Habits, "Oral Hygiene," and "Periodontal Health," when selecting topics for athlete-specific OHI.			
☐ Routine brushing and flossing	☐ Cavities and restoration	☐ Periodontal disease	☐ Periodontitis and diabetes
☐ Preventing trauma	☐ Cleaning partial/dentures	☐ Adaptive oral hygiene tools	☐ Over-retained primary teeth

Station 3: Mouth Guard (Optional)

Screener's Name:

Is this station offered at the Special Smiles Screening? ◯ Yes ◯ No	Athlete provided a mouth guard: ◯ Yes ◯ No *If yes, indicate the size provided and brand:* Size: _____ Brand: _____ *If no,* ◯ Not indicated ◯ Unable to complete fitting
Was mouth guard fitting recommended in Station Designations? ◯ Yes ◯ No	
Mouth guard care and instructions: ◯ Provided ◯ Unable to complete	

Station 4: Fluoride Varnish (Optional)

Screener's Name:

Is this station offered at the Special Smiles Screening?
◯ Yes ◯ No

Was fluoride varnish recommended in Station Designations?
◯ Yes ◯ No

Post fluoride varnish application instructions:
◯ Provided ◯ Unable to complete

Fluoride varnish application completed:
◯ Yes ◯ No
If no,
◯ Not indicated ◯ Unable to complete

Station 5: Oral Hygiene Instructions

Screener's Name:

Was specific Oral Hygiene Instruction (OHI) recommended in Determination of Oral Hygiene Instruction Needs? ◯ Yes ◯ No

Check which oral hygiene topics were provided to the athlete at the OHI station:

☐ Routine brushing and flossing	☐ Cavities and restoration	☐ Periodontal disease	☐ Periodontitis and diabetes
☐ Preventing trauma	☐ Cleaning partial/dentures	☐ Adaptive oral hygiene tools	☐ Over-retained primary teeth

Was anyone from the athlete's support system present for their oral hygiene instruction? ◯ Yes ◯ No
If yes, who was present? ☐ Parent/Guardian ☐ Caretaker ☐ Coach

Station 6: Check Out

Screener's Name:

Screening Completion
Was the screening <u>unable</u> to be completed and/or concluded prior to completion for any reason?
◯ Screening Complete ◯ Screening Incomplete
If screening incomplete, please describe: _____

Follow-up recommended? ◯ Yes ◯ No
If yes, please select appropriate provider(s) below and select the most elevated referral type based on results of screening.

☐ **Dentist**	◯ Routine Follow-up	Continue with routine follow-up with a **dental provider** at least every 6 months.
	◯ Non-Urgent Referral	<u>Reasons for Recommendation:</u> ☐ Pain ☐ Decayed, missing, or filled teeth ☐ Signs of periodontal disease ☐ Signs of injury or trauma ☐ Mouth guard needed ☐ Comprehensive dental exam (>1 yr)
	◯ Urgent Referral	<u>Reasons for Recommendation:</u> ☐ Pain ☐ Decayed, missing, or filled teeth ☐ Signs of periodontal disease ☐ Signs of injury, trauma, or infection
	Please provide Name/Location of Referral: _____	◯ Provider list dispensed
☐ **Other** **(please specify):** _____	◯ Non-Urgent Referral	<u>Reasons for Recommendation:</u> _____
	◯ Urgent Referral	<u>Reasons for Recommendation:</u> _____
	Please provide Name/Location of Referral: _____	◯ Provider list dispensed