

Station 1: 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
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

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:

No Pain				Moderate Pain						Worst Pain	
0	1	2	3	4	5	6	7	8	9	10	

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	<p>Is a follow-up intraoral cancer screening indicated?</p> <p>Yes No Unable to test</p> <p><i>If yes, localized to:</i></p> <p>Right Left Mid</p> <p><i>Localized intraorally to:</i></p> <p>Hard Palate Soft Palate Tongue Tonsillar Area Upper Lip Lower Lip Upper Gingiva Lower Gingiva Upper Mucosa Lower Mucosa Upper Vestibule Lower Vestibule</p>
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Dental Trauma	<p>Do you play any contact sports?</p> <p>Yes No I don't know Did not answer</p> <p>Is there dental trauma?</p> <p>Yes No Unable to test</p> <p><i>If yes, localized to:</i></p> <p>Upper Right Upper Anterior Upper Left Lower Left Lower Anterior Lower Right None of the above</p> <p><i>Localized intraorally to:</i></p> <p>Hard Palate Soft Palate Tongue Tonsillar Area Upper Lip Lower Lip Gingiva Mucosa Vestibule Dentition</p> <p><i>Is there pain associated with trauma?</i></p> <p>Never Pain Pain that lasted ≤ 3 months Pain that lasted > 3 months</p> <p><i>If there was pain, is that pain now resolved?</i></p> <p>Yes No Unable to test</p> <p><i>Date of traumatic incident associated with pain referenced:</i> (MM/YYYY): _____ I don't know Did not answer</p> <p><i>Has the athlete received treatment for trauma referenced?</i></p> <p>Treated In Treatment/Monitoring Not in Treatment/Needs Referral</p>
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Abscess, Exudate, Swelling, Ulceration, and Sore Spot Unable to test	Abscess or Sinus Track <i>Localized to:</i> Upper Right Lower Left Upper Anterior Lower Anterior Upper Left Lower Right	Exudate <i>Localized to:</i> Upper Right Lower Left Upper Anterior Lower Anterior Upper Left Lower Right	Swelling <i>Localized to:</i> Intra Oral Extra Oral Upper Right Lower Left Upper Anterior Lower Anterior Upper Left Lower Right
	Ulceration <i>Localized to:</i> Corners of mouth Hard Palate Vestibule Upper Right Lower Left Upper Anterior Lower Anterior Upper Left Lower Right	Sore Spot <i>Localized to:</i> 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 <i>Localized to:</i> Upper Right Lower Left Upper Anterior Lower Anterior Upper Left Lower Right	Calculus Generalized Localized <i>Localized to:</i> Upper Right Lower Left Upper Anterior Lower Anterior Upper Left Lower Right	Atypical Saliva <i>Description:</i> Dry mouth Excessive saliva Bubbles Thick Ropey Cloudy/White Other																		
	Fluorosis Generalized Localized <i>Localized to:</i> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:25%;">Upper Right:</td> <td style="width:12.5%;">Moderate</td> <td style="width:12.5%;">Severe</td> <td style="width:25%;">Lower Left:</td> <td style="width:12.5%;">Moderate</td> <td style="width:12.5%;">Severe</td> </tr> <tr> <td>Upper Anterior:</td> <td>Moderate</td> <td>Severe</td> <td>Lower Anterior:</td> <td>Moderate</td> <td>Severe</td> </tr> <tr> <td>Upper Left:</td> <td>Moderate</td> <td>Severe</td> <td>Lower Right:</td> <td>Moderate</td> <td>Severe</td> </tr> </table>				Upper Right:	Moderate	Severe	Lower Left:	Moderate	Severe	Upper Anterior:	Moderate	Severe	Lower Anterior:	Moderate	Severe	Upper Left:	Moderate	Severe	Lower Right:	Moderate
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 <i>Localized to:</i> Upper Right Lower Left Upper Anterior Lower Anterior Upper Left Lower Right	Inflammation/ Swelling Generalized Localized <i>Localized to:</i> Upper Right Lower Left Upper Anterior Lower Anterior Upper Left Lower Right	Crowding or Malocclusion Generalized Localized <i>Localized to:</i> Upper Right Lower Left Upper Anterior Lower Anterior Upper Left Lower Right
	Tooth Mobility Generalized Localized <i>Localized to:</i> Upper Right Lower Left Upper Anterior Lower Anterior Upper Left Lower Right		

Dentition Unable to test	<u>Dentition Inventory: Decayed, Missing, Filled Teeth</u> 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 <i>If yes, localized to:</i> Premolar(s) Molar(s) Primary Molar(s)
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Over-Retained Primary Teeth	Are there over-retained primary teeth? Yes No Unable to test <i>If yes, localized to:</i> Upper Right Upper Anterior Upper Left Lower Left Lower Anterior Lower Right
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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
<i>If any of the above are answered yes, an urgent referral is indicated.</i>	
Positive screen for risk of gingivitis and/or periodontitis?	Yes No
<i>If yes, a non-urgent referral is indicated.</i>	
Are there any teeth that are decayed or missing?	Yes No
<i>If yes, a non-urgent referral is indicated for decay without evidence of infection, routine follow-up care is indicated for missing teeth.</i>	
<i>Note: If the only concern is missing teeth, and the missing teeth are restored in any capacity (removable or fixed), consider a routine referral.</i>	

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:	
<ul style="list-style-type: none"> ▪ <i>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.</i> ▪ <i>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.</i> 	
Mouth Guard Station	Fluoride Varnish Station

Determination of Oral Hygiene Instruction Needs			
<i>Consider sections "Oral Health Care Habits," "Oral Hygiene," and "Periodontal Health," when selecting topics for athlete-specific OHI.</i>			
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 <i>If yes, indicate the size provided and brand:</i> Size: _____ Brand: _____ <i>If no,</i> 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	Fluoride varnish application completed: Yes No <i>If no,</i> Not indicated Unable to complete
Was fluoride varnish recommended in Station Designations? Yes No	
Post fluoride varnish application instructions: Provided 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? <i>If yes, who was present?</i>		Yes	No
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 <i>If screening incomplete, please describe:</i> _____	

Follow-up recommended? Yes No <i>If yes, please select appropriate provider(s) below and select the most elevated referral type based on results of screening.</i>		
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: _____ <div style="text-align: right;">Provider list dispensed</div>	
Other (please specify):	Non-Urgent Referral	<u>Reasons for Recommendation:</u> _____
	Urgent Referral	<u>Reasons for Recommendation:</u> _____
	Please provide Name/Location of Referral: _____ <div style="text-align: right;">Provider list dispensed</div>	