Scottish Dental
Clinical Effectiveness Programme

SDCEP

Oral Health Assessment and Review

Guidance in Brief

March 2011

Scottish Dental
Clinical Effectiveness Programme

The Scottish Dental Clinical Effectiveness Programme (SDCEP) is an initiative of the National Dental Advisory Committee (NDAC) and is supported by the Scottish Government and NHS Education for Scotland. The Programme aims to provide user-friendly, evidence-based guidance for the dental profession in Scotland.

SDCEP guidance is designed to help the dental team provide improved care for patients by bringing together, in a structured manner, the best available information that is relevant to priority areas in dentistry, and presenting this information in a form that can be interpreted easily and implemented.

'Supporting the dental team to provide quality patient care'

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Dental Health Services Research Unit

Scottish Dental
Clinical Effectiveness Programme

SDCEP

Oral Health Assessment and Review

Guidance in Brief

March 2011

ISBN 978 1 905829 11 8
First published March 2011

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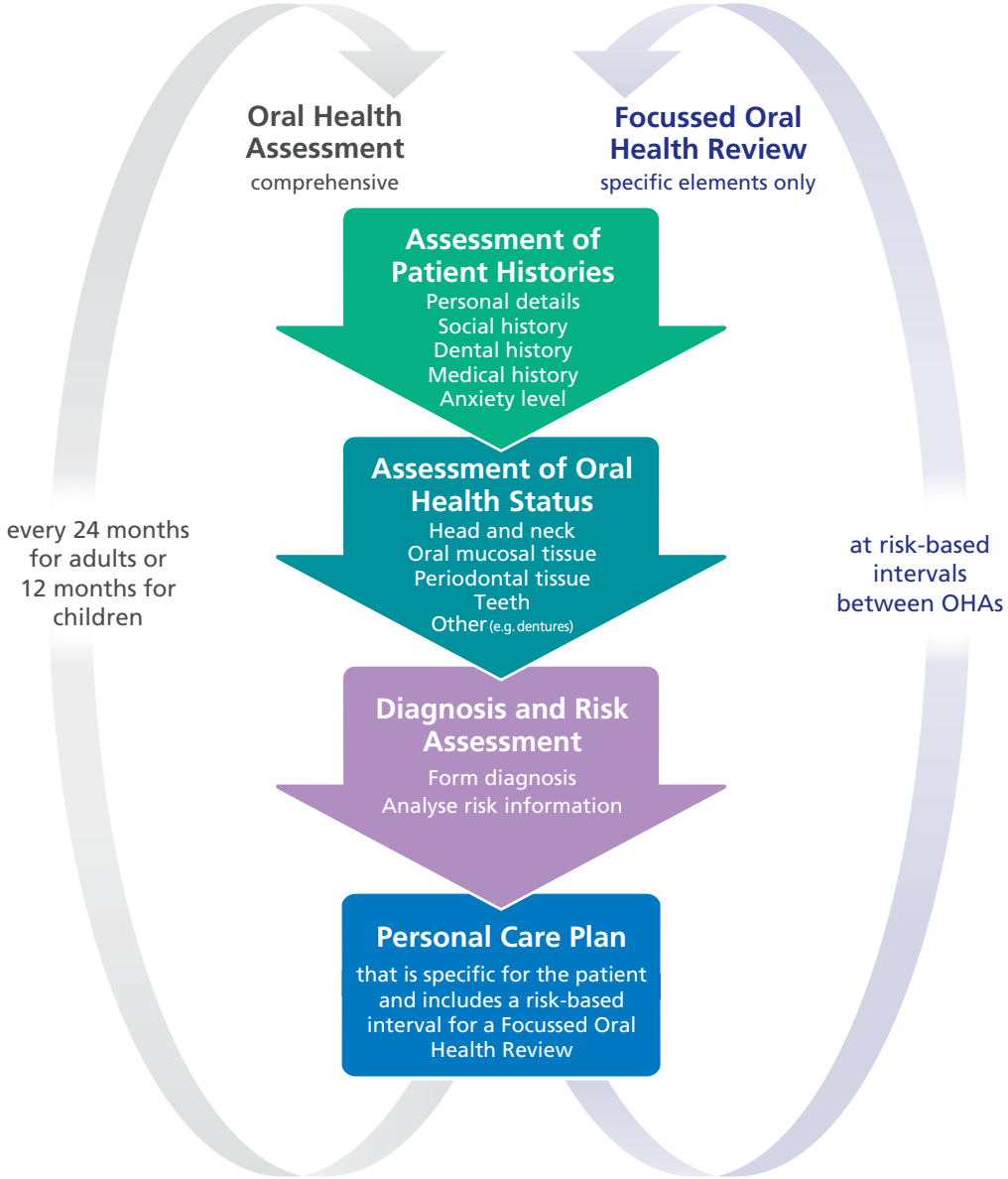


What is Oral Health Assessment and Review?

In routine primary dental care, Oral Health Assessment and Review involves a comprehensive assessment of a patient's histories and oral health status that leads to diagnosis and risk assessment, followed by personalised care planning and ongoing review.

A key aim of Oral Health Assessment and Review is to facilitate the move from a restorative approach to patient care to a preventive and long-term approach that is risk-based and meets the specific needs of individual patients. It also aims to encourage the involvement of patients in managing their own oral health.

For a personal care plan to meet the changing needs of a patient, it is important that on registering with a dental practice, each patient receives a baseline Oral Health Assessment (OHA). For adults, this is a comprehensive assessment that is repeated every 24 months. For children, the first OHA should be conducted as early as possible, and no later than three years of age, and repeated at 12 month intervals. In addition for both adults and children, during these time periods Focussed Oral Health Reviews (FOHRs) can be carried out. Both the number of FOHRs and the intervals between them will vary depending on the patient's risk of future oral disease (see Figure 1).

For patients who attend only for urgent care (e.g. pain relief), this approach is not appropriate. Instead, a basic assessment that enables the management of the patient's immediate needs is sufficient. This should also always include taking a medical history and examination of oral mucosal tissue. Such irregular symptomatic attenders should be invited to attend for regular care, which would begin with a comprehensive OHA.

To facilitate the delivery of quality care to patients, effective communication, good team-working and comprehensive and accurate record-keeping are essential. Not all elements of Oral Health Assessment and Review need to be conducted by a dentist. Other members of the dental team might be well placed to help in the process of taking patient histories, recording results of clinical examinations or explaining care to patients. Practising within medico-legal constraints (e.g. regarding confidentiality, consent and capacity, record-keeping and data protection) is also essential from both an ethical and a professional perspective.

This Guidance in Brief summarises the elements of Oral Health Assessment and Review. The process is illustrated in Figure 1 and actions for the dental team are shown as bulleted lists in coloured boxes. Diagrams are included to illustrate general concepts.

What is Oral Health Assessment and Review?

Sources of further information are given at the end of each section. Additional resources to assist the dental team in following this guidance, including a full version of the guidance, are available online (see Appendices for details).

This approach to assessment incorporates improved monitoring to underpin the provision of high-quality patient care and reflects changes taking place internationally. Clearly, fully implementing this approach may represent a significant change to current practice and will take time. However, aspects of this approach could be adopted in stages.

Further details

- Appendix 1 summarises the development of this guidance and its intended use.
- In creating this Guidance in Brief, much of the detail of this complex topic has intentionally been omitted. For further background to Oral Health Assessment and Review, additional details about effective communication, record-keeping and practising within medico-legal constraints, and details of the guidance development process, see the full guidance available at www.scottishdental.org/cep.

Assessment of Patient Histories

The first stage of an OHA is to assess the patient's histories and general well-being. A key purpose of collecting this general information is to identify any modifying factors, including both risk and protective factors, that will contribute to the assessment of the patient's risk of future oral disease and inform the future care of the patient.

- Collect or update patient histories that include:
  - personal details (e.g. name, address)
  - dental history (e.g. previous treatment)
  - social history (e.g. smoking status, alcohol intake)
  - medical history (e.g. current medication and conditions)

  NB: Most patients will be able to provide this information by completing a form. Some might require assistance with some or all of the questions. For children or patients requiring additional support, it might be necessary to collect some of the above information from parents or carers.
- Assess whether the patient is anxious and, if so, ask them to complete a dental anxiety questionnaire, which can help to alleviate their anxiety and inform the personal care plan.
- Review the patient histories and ensure that the information provided is up to date and accurate.
- From the patient histories, identify and record any modifying factors that might affect future dental treatment and care or the risk of developing oral health problems.
- Assess the patient's experience of, and attitude to, dental care (e.g. see the dental and social history form).
- Assess the patient's ability to understand the care provided.

Further details

- For a list of modifying factors, see Appendix 2.
- Example forms for collecting patient histories can be downloaded at www.scottishdental.org/cep.

Assessment of Oral Health Status

The second stage of an OHA is to carry out a full clinical assessment of the patient's oral health status. This involves an extra-oral examination of the head and neck and an intra-oral examination of the oral mucosal tissue, periodontal tissue, teeth, occlusion and, if present, dentures. A thorough clinical assessment enables early diagnosis of any disease and identification of further modifying factors. Together with the assessment of patient histories, this will help identify the patient's risk of future oral disease and inform individualised preventive-orientated care and treatment of the patient.

- Conduct a comprehensive extra-oral examination of the patient's head and neck, including:
  - skin (including swellings)
  - facial bones
  - lymph nodes
  - temporomandibular joint
- Conduct a comprehensive intra-oral examination of the patient's oral health status, including:
  - oral mucosal tissue
  - periodontal tissue
  - teeth (including assessment of clean, dry teeth for initial and advanced caries, restorations, tooth surface loss, tooth abnormalities, fluorosis and trauma)
  - occlusion and orthodontic needs
  - dentures (if present)
- Undertake appropriate radiographic assessment based on clinical findings and record details.
- Assess compliance with preventive advice and the effectiveness of previous treatments.
- Record that each element has been completed and record any positive clinical findings from the assessments.
- Identify and record any modifying factors present.

Assessment of Oral Health Status

Further details

- For a list of modifying factors, see Appendix 2.
- Example forms for recording results of clinical examinations and details of radiographs can be downloaded at www.scottishdental.org/cep.
- A checklist for recording completion of elements of the clinical examination is included in Appendix 3 and can be downloaded at www.scottishdental.org/cep.
- The full guidance provides further details about each element of the extraoral and intraoral examination, including some established assessment methods such as the Basic Periodontal Examination (BPE) for periodontal disease. It also describes a newer caries lesion assessment system that is currently being implemented internationally and being developed for use in practice.

Diagnosis and Risk Assessment

The third stage of an OHA is to diagnose disease and assess the patient's individual risk of developing oral disease in the future. There are wide variations between patients in their susceptibility to disease, the likelihood of early disease progressing and the speed of disease progression, if it occurs. Therefore, to provide care that meets the current oral health needs of each patient, it is important to consider patient-specific information. This will help in assessing each patient's individual risk of developing both common and less common oral diseases and conditions and in developing a personal care plan that includes appropriate preventive advice and treatment options to improve the patient's oral health and reduce the patient's risk level.

The National Institute for Health and Clinical Excellence (NICE) has recommended that the patient's recall interval between routine dental examinations is based on the individual's risk of oral disease. NICE and the Faculty of General Dental Practice identified three key areas where they felt assessment of modifying factors is important to determine the dental recall interval:

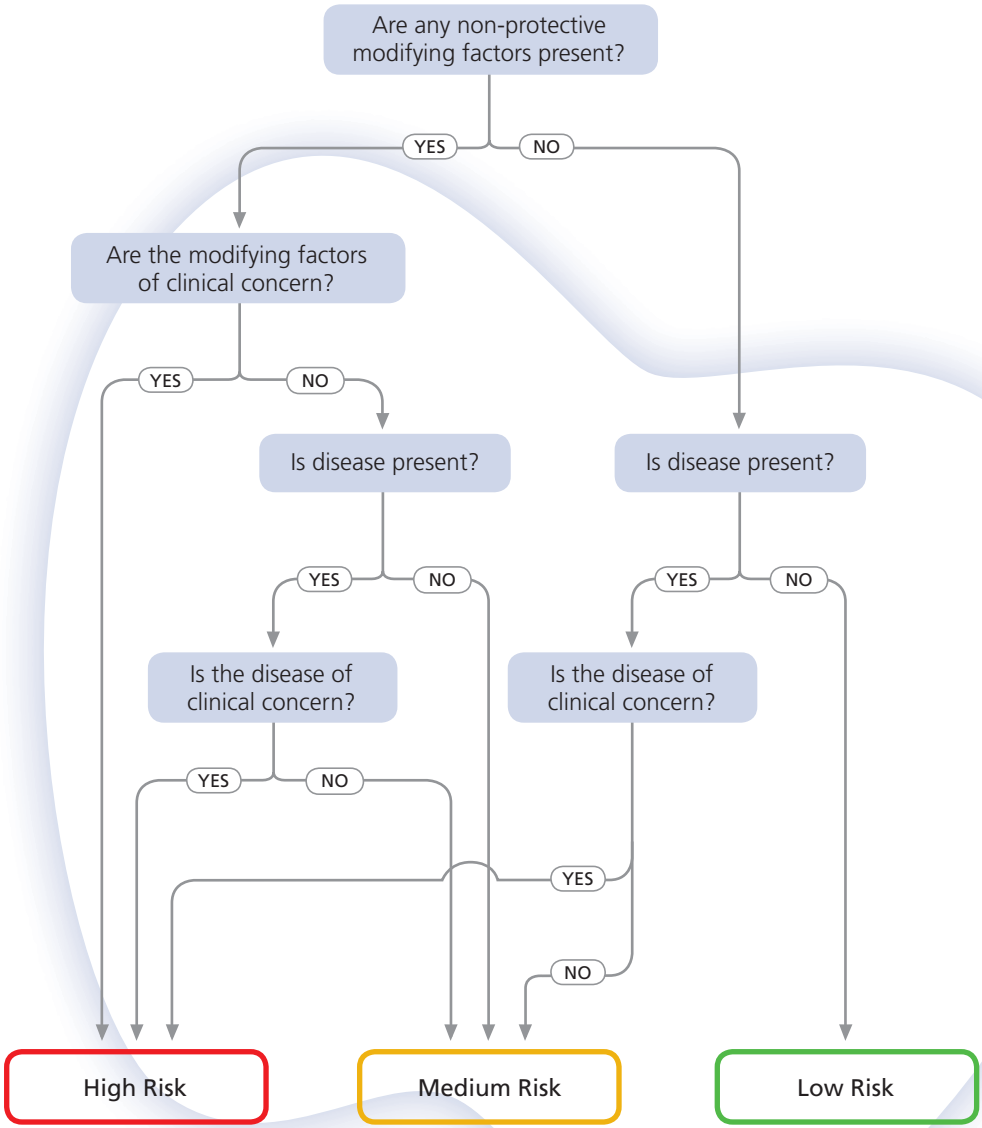
- dental caries
- periodontal disease
- oral cancer

A risk assessment involves the use of clinical judgement and knowledge of the patient to assess modifying factors identified in the patient's histories that affect the development of dental caries, periodontal disease and oral mucosal disease and integrating this information with assessment of the modifying factors and disease identified during the clinical examination. A risk level is then assigned for each of caries, periodontal disease and oral mucosal disease for each patient. Figure 2 shows a simplified illustration of the risk assessment process.

Taking into account the risk levels for each of the main elements of the OHA, an overall risk level for the patient can then be assigned. This is used to determine the interval to the next Focussed Oral Health Review.

Diagnosis and Risk Assessment

Figure 2 Assigning a risk level for the development of oral disease



Diagnosis and Risk Assessment

- Review the modifying factors identified in the patient's histories and during each element of the clinical examination and evaluate the impact of these factors in relation to the patient's past disease experience and newly diagnosed disease.
- Predict the risk of future disease and assign an individual risk level (high, medium, low) for caries, periodontal disease, oral mucosal disease for each patient, bearing in mind:
  - possible inaccurate self-reporting by patients;
  - risk factors and protective factors can change over time;
  - past disease experience might not always be a reliable predictor of future disease;
  - the patient's attitude to care, and ability and willingness to cooperate.
- Carry out a risk assessment in a similar way for any other aspects of the patient's oral health (e.g. trauma, tooth surface loss, occlusion, orthodontics) that might influence their future care.
- Assign an overall risk level for the patient (high, medium or low).
- Assign an interval for a Focussed Oral Health Review (FOHR) for the patient, if required, that is based on their overall risk level and specific to their needs within the following ranges:
  - Adults: 3–24 months
  - Children (<18 years): 3–12 months

  NB: For a new patient, it is advised that a conservative review interval is assigned and then at subsequent review appointments the interval can be extended incrementally if no new problems are encountered.
- Discuss and agree with the patient their risk of developing disease and discuss and explain the reasoning for the review interval and the fact that this might change over time.
- Confirm the interval until the next OHA (24 months for adults; 12 months for children).

Diagnosis and Risk Assessment

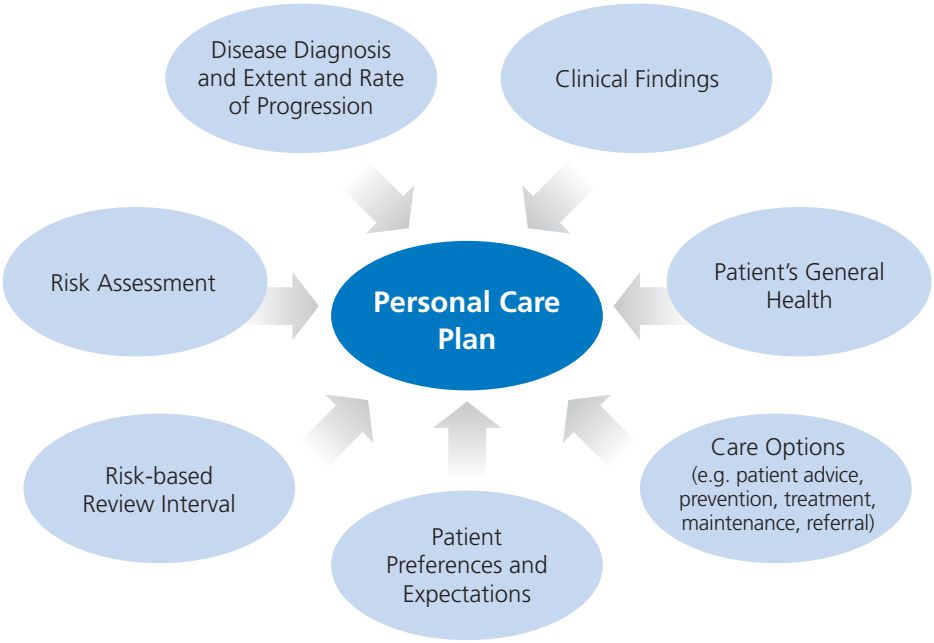
Further details

- For a list of modifying factors, see Appendix 2.
- An example form to help communicate the findings of the assessment to the patient and an assessment checklist are included in Appendix 3 and can be downloaded at www.scottishdental.org/cep.

Development of a Personal Care Plan

The fourth stage of an OHA is to develop a personal care plan for each patient. A personal care plan is a risk-based long-term plan that is designed to address the patient's individual oral health improvement and maintenance needs. Figure 3 illustrates that several factors need to be considered when developing a personal care plan.

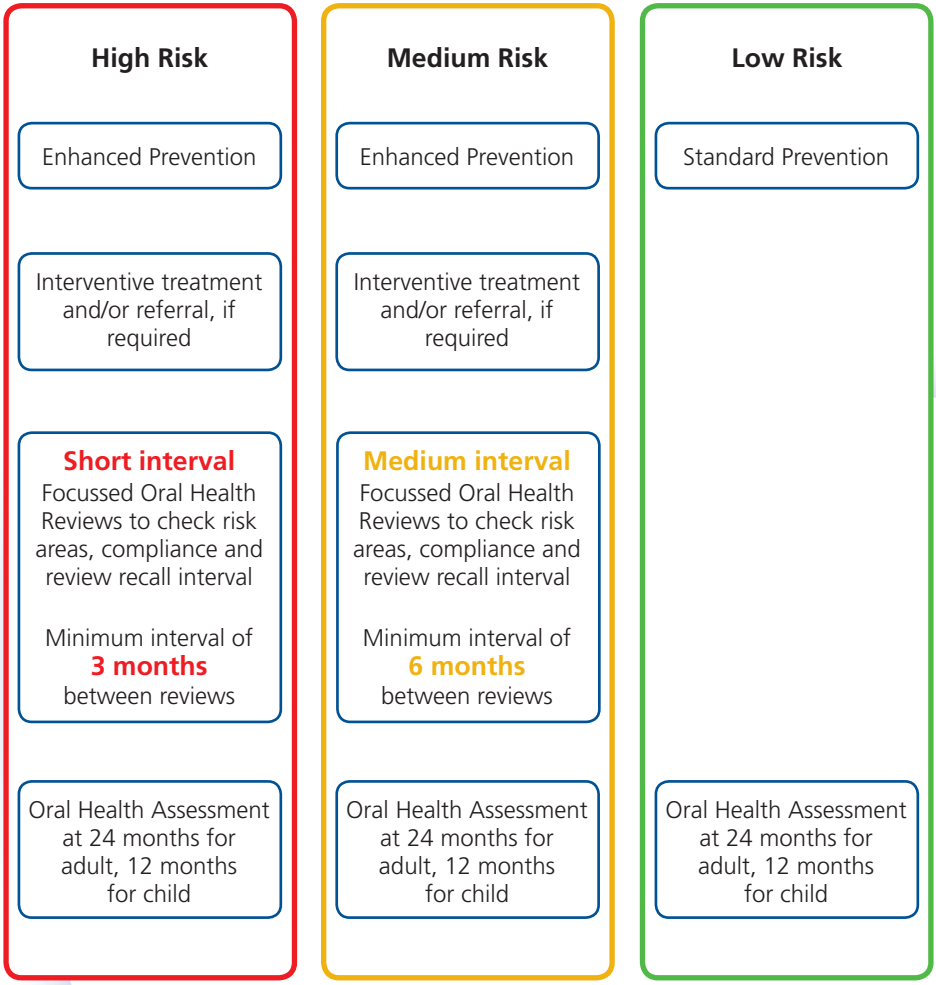
Figure 3 Summary of the points to consider in the development of a personal care plan



The components of a personal care plan including the frequency of assessments will vary between patients and depend on whether the patient's overall risk level has been assessed as high, medium or low. This is illustrated in Figure 4.

Development of a Personal Care Plan

Figure 4 Variation in personal care plans for the three overall risk levels



Note that for a new patient assessed as low risk, a conservative interval for Focussed Oral Health Reviews is advised initially which can be extended incrementally if no new problems are encountered.

Development of a Personal Care Plan

- Discuss care options with the patient
- When developing the personal care plan, consider:
  - the extent and rate of disease progression;
  - the patient's age and general health (medical history);
  - the care options that are most appropriate for the patient to maintain and improve their oral health;
  - the patient's preferences, expectations and willingness to comply with the plan;
  - whether you can treat all aspects or whether the patient requires referral to a specialist;
  - whether any treatments need to be carried out in stages in order to:
    - aid and assess the compliance of the patient with preventive care
    - optimise the successful completion of complex treatments;
  - any clinical findings that might compromise or affect treatment procedures or outcomes (e.g. limited mouth opening, TMJ problems, xerostomia);
  - your assessment of the patient's overall risk of disease.
- Include in the long-term personal care plan:
  - patient advice (e.g. with respect to oral hygiene, diet, visiting a smoking cessation centre);
  - an individualised risk-based interval for a Focussed Oral Health Review (FOHR) (if required);
  - interval before the next OHA;

  and, if appropriate:
  - preventive treatments (e.g. fluoride varnish, fissure sealants, oral hygiene instruction);
  - operative treatments (e.g. restorations);
  - endodontic treatments;

Development of a Personal Care Plan

  - maintenance and monitoring (e.g. appointment with hygienist for scale and polish or advice on flossing, etc.);
  - referral to a specialist.

- Discuss and agree the personal care plan with the patient, explaining:
  - the concept and advantages of a personal care plan (e.g. it is specific to the individual needs of the patient);
  - the concept of a more preventive, long-term care plan (e.g. it is less invasive and leaves options for the future);
  - the review interval that is specific to the oral health needs of the patient;
  - the role of the patient and the role of the dental team in maintaining and improving the patient's oral health.
- Ensure that all discussions with the patient are appropriate to their age and capacity and that child patients, including young children, are included in discussions about their care.
- Record the agreed personal care plan and give the patient a copy (e.g. use the example Patient Review and Personal Care Plan form).

Further details

- An example form to help communicate the findings of the assessment to the patient and an assessment checklist are included in Appendix 3 and can be downloaded at www.scottshdental.org/cep.

Focussed Oral Health Review

The ongoing review of a patient's oral health includes:

- Focussed Oral Health Reviews (FOHRs) conducted at risk-based intervals (minimum 3 months) to reassess elements previously identified at high or medium risk, and
- Oral Health Assessment (OHAs) completed every 24 months for adults and 12 months for children.

The FOHR is used to identify whether any clinical elements or modifying factors identified previously have changed and to ensure that the patient's personal care plan (including risk level and review interval) is still appropriate to meet the needs of the patient. A comprehensive OHA is conducted periodically to re-assess the overall oral health status of the patient, and amend the patient's personal care plan appropriately.

At the Focussed Oral Health Review appointment:

- ensure patient histories are up to date;
- check patient compliance with preventive advice given;
- check the effectiveness of any treatment provided;
- reassess in full any clinical elements that were previously assigned high or medium risk, and any other elements as appropriate for the patient;
- review the risk level for the patient, taking into account any changes in risk factors and protective factors and new clinical findings;
- review the patient's personal care plan and amend if necessary.
- confirm the interval before the next FOHR or OHA.

Appendix 1
About The Oral Health Assessment and Review Guidance

A Guidance Development Group, comprising individuals from a range of branches of the dental profession, was convened to develop and write this guidance. This group works closely with the Programme Development Team, which facilitates all aspects of guidance development. Draft guidance was subject to wide consultation and this Guidance in Brief version was created in response to feedback received. Updating of the full guidance (available online at www.scottishdental.org/cep) is ongoing. The full guidance describes in more detail the background and general principles or oral health assessment and review, each stage of the assessment and the guidance development methodology and includes supporting tools and references.

This guidance has resulted from a careful consideration of current legislation, professional regulations, the available evidence and the opinion of experts and experienced practitioners. It should be considered when conducting any examination and discussing care planning with a patient and/or carer. As guidance, the information presented here does not override the health professional's right and duty to make decisions appropriate to each patient.

Appendix 2
Summary of Modifying Factors

The following table lists in alphabetical order modifying factors that may be identified from patient histories and the assessment of oral health status. Modifying factors include risk and protective factors, behaviours and clinical findings that are associated with the development of oral disease and conditions. These should be considered when determining the risk-based frequency of Focussed Oral Health Reviews.

Patient Histories

- Conditions that increase a patient's risk of developing dental disease (e.g. diabetes, xerostomia as a result of, for example, Sjogrens syndrome, certain drugs or head and neck radiation therapy)
- Conditions that might complicate dental treatment or the patient's ability to maintain their oral health (e.g. special needs or anxious, nervous, phobic conditions)
- Conditions where dental disease could put the patient's general health at increased risk (e.g. patients on warfarin, immunosuppression)
- Excessive alcohol use (>21 units of alcohol per week for men; >14 units of alcohol per week for women)
- Family history of chronic or aggressive (early onset/juvenile) periodontitis
- Ghukta, Paan (betel quid with tobacco), Areca nut use
- High and/or frequent dietary acid intake
- High and/or frequent sugar intake
- High caries rates in mother and siblings (applies to children only)
- Poor level of oral hygiene
- Residence in a deprived (low SIMD) area
- Tobacco use
- Use of ≥1000 ppm fluoride toothpaste (protective factor)
- Use of other sources of fluoride or resident in a water-fluoridated area (protective factor)

Head and Neck

- Craniofacial abnormalities
- Limited mouth opening
- Neck (lymph node) swelling
- Suspicious skin lesions (basal or squamous cell carcinomas, melanomas)
- TMJ problems

Oral Mucosal Tissue

- Betel quid chewing
- Diets low in fruit and vegetables
- Excessive alcohol use (>21 units of alcohol per week for men; >14 units of alcohol per week for women)

Appendix 2
Summary of Modifying Factors

- Low saliva flow rate (dry mouth)
- Mucosal lesion present
- Outdoor workers
- Tobacco use

Periodontal Tissue

- Bony loss observed on sequential radiographs
- BPE scores of 3,4,* in patients under 35 years of age
- Concurrent medical factor that is directly affecting the periodontal tissues (e.g. diabetes, stress, certain medication)
- Evidence of gingivitis
- Family history of chronic or aggressive (early onset/juvenile) periodontitis
- Family history of early tooth loss due to periodontal disease
- High % of bleeding on probing in relation to a low plaque index
- Poor level of oral hygiene
- Presence of plaque-retaining factors
- Previous history of treatment for periodontal disease
- Rapid periodontal breakdown >2mm attachment loss per year
- Root morphology that affects prognosis
- Smoking 10+ cigarettes a day

Dental Caries

- Anterior caries or restorations
- Healthcare worker's opinion (esp. children)
- Heavily restored dentition
- High and/or frequent sugar intake
- High caries rates in mother and siblings (applies to children only)
- Low saliva flow rate (dry mouth)
- New lesions since last check-up
- Past root caries or large number of exposed roots
- Poor dietary behaviours
- Poor level of oral hygiene
- Premature extractions because of caries
- Previous carious experience
- Resident in an area of deprivation
- Use of ≥1000 ppm fluoride toothpaste (protective factor)
- Use of other sources of fluoride or resident in a water-fluoridated area (protective factor)

Appendix 2
Summary of Modifying Factors

Tooth Surface Loss

- Bruxism
- Clinical evidence of tooth wear
- High and/or frequent dietary acid intake (e.g. high consumption of acidic drinks such as carbonated drinks, citrus fruit and fruit juices)
- Predisposing medical and drug factors: for example, impaired salivary production or buffering ability; gastric reflux (often associated with Hiatus hernia); eating disorders such as anorexia nervosa, bulimia and pica; and the frequent use of some medicines and supplements such as steroid-containing asthma inhalers, vitamin C tablets and effervescent preparations
- Rapid progression of tooth wear
- Stress and/or anxiety

Tooth Abnormalities

- Family history
- Tooth abnormalities (tooth number, size, shape, colour)

Fluorosis

- Eating/licking toothpaste habit
- Exposure to fluoridated water, in conjunction with other factors, up to 3 years of age
- Inappropriate use of fluoride supplements or toothpaste
- Unsupervised toothbrushing (under 6 years)

Orthodontic Status

- Canine in the line of the arch but failing to erupt, 10–13 years of age
- Failure of teeth to erupt at the expected time
- First permanent molars of poor prognosis when hypodontia or skeletal discrepancy present
- Palatally ectopic or buccally impacted canines
- Patients requiring orthodontics as part of a multidisciplinary treatment plan

Dentures

- Poor denture and oral hygiene

Further details

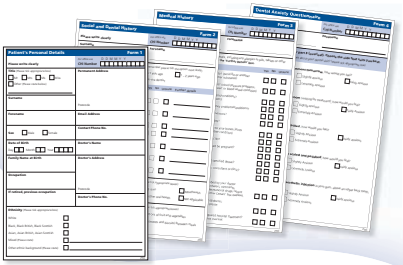
- Supporting references are available in the full guidance.

Appendix 3
Online Resources

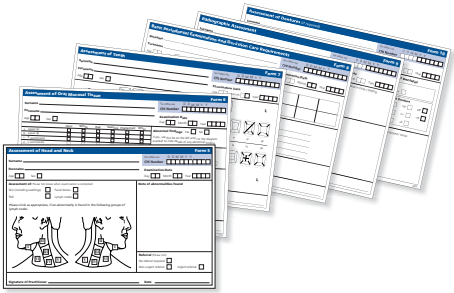
To assist the dental team in following this guidance, various additional resources are available to download from the SDCEP website (www.scottishdental.org/cep) for printing or adapting to suit your needs. These include:

Example Recording Forms to illustrate the information to be gathered as part of oral health assessment and review.

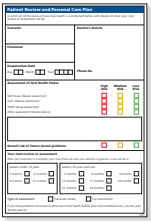
- Patient's Personal Details
- Social and Dental History
- Medical History
- Dental Anxiety Questionnaire



- Assessment of Head and Neck
- Assessment of Oral Mucosal Tissue
- Assessment of Teeth
- Basic Periodontal Examination and Dentition Care Requirements
- Radiographic Assessment
- Assessment of Dentures



- Patient Review and Personal Care Plan



An increasing number of dental practices use software with automated data collecting and charting. Therefore, it is not essential that these example forms are used. However, it is recommended that all the information indicated in the example forms is collected using whichever system is most suitable for each dental team. Each example form is designed so that it can be used independently, if appropriate.

Appendix 3
Online Resources

A **Checklist** which can be used for both Focussed Oral Health Reviews (FOHRs) and Oral Health Assessments (OHAs) to record which elements of assessment have been conducted and the outcomes of the assessment.

The example Patient Review and Personal Care Plan form and the checklist are also reproduced on the following pages.

The **Full Guidance** – a more detailed version with more explanation of the background and general principles of Oral Health Assessment and Review, each stage of the assessment and the guidance development process plus other supporting tools and references.

Patient Review and Personal Care Plan

A summary of the status of your oral health is summarised below with details of when your next review or assessment will be.

Surname

Forename

Examination Date

Day ☐☐ Month ☐☐ Year ☐☐☐☐

Dentist's Details

Phone No.

Assessment of Oral Health Status

	High Risk	Medium Risk	Low Risk
Soft tissue disease assessment	☐	☐	☐
Gum disease assessment	☐	☐	☐
Tooth decay assessment	☐	☐	☐
Other assessment (details below)	☐	☐	☐

Overall risk of future dental problems ☐ ☐ ☐

Your next review or assessment

After your treatment is complete, your next check-up with your dentist / hygienist / nurse will be in:

patient under 18 years

3 months ☐ 6 months ☐

9 months ☐ 12 months ☐

patient 18 years and over

3 months ☐ 6 months ☐ 9 months ☐

12 months ☐ 15 months ☐ 18 months ☐

21 months ☐ 24 months ☐

Type of assessment ☐ Focussed review ☐ Full assessment

If you have problems or concerns about your oral health before your next scheduled visit, contact your dental practice.

PTO

Patient Review and Personal Care Plan (cont.)

Things you can do to maintain or improve your oral health are shown below followed by what the dental team plans to do.

Actions for the Patient

Actions for the Dental Team

Prevention

Treatment

Maintenance

Referral

Signature of Patient, Parent or Carer **Date**

Signature of Practitioner **Date**

Oral Health Assessment and Review Checklist

Patient Name

For office use

CHI Number D D M M Y Y

Assessment Type FOHR / OHA

Date of Assessment Day Month Year

Patient Histories Completed/Updated*	**Yes**	**No**	**Comment**
• Personal details	☐	☐	
• Social history	☐	☐	
• Dental history	☐	☐	
• Medical history	☐	☐	
• Dental anxiety level	☐	☐	
• Dentist reviewed histories	☐	☐	

**If new patient, complete new forms; if returning patient, ask patient if anything has changed and review forms completed previously*

Clinical Assessment Completed/Updated*	**Yes**	**No**	**Comment**
• Head and neck	☐	☐	
• Oral mucosal tissue	☐	☐	
• Periodontal tissue (BPE/plaque scores)	☐	☐	
• Teeth - Caries and restorations	☐	☐	
- Tooth surface loss	☐	☐	
- Tooth abnormalities	☐	☐	
- Fluorosis	☐	☐	
- Dental trauma	☐	☐	
• Occlusion	☐	☐	
• Orthodontic needs	☐	☐	

	Yes	**No**	**N/A**	
Dentures	☐	☐	☐	

**Record full details of any significant findings separately.*

	Good	**Poor**	**N/A**	**Comment**
Effectiveness of treatment	☐	☐	☐	
	Yes	**No**		
Patient compliance with advice	☐	☐		

Risk Assessment	**High**	**Medium**	**Low**	**Comment**
• Oral mucosal disease	☐	☐	☐	
• Periodontal disease	☐	☐	☐	
• Caries	☐	☐	☐	
• Other (please note)	☐	☐	☐	
OVERALL RISK	☐	☐	☐	

	Yes	**No**	**Comment**
Prevention advice given	☐	☐	
Preventive treatment required	☐	☐	
Operative treatment required	☐	☐	

Review Interval (months) (following completion of any treatment):

3 6 9 12 15 18 21 24

Proposed date for next OHA (following completion of any treatment):

	No Change	**Change**	**Comment**
Personal Care Plan Review	☐	☐	

NHS Education for Scotland

NDAC

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