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?	☐	☐
2.	Have you, or anyone living with you had contact with someone with a confirmed or suspected diagnosis of COVID-19?	☐	☐
3.	Have you, or anyone living with you returned from overseas in the last 14 days?	☐	☐
4.	Do you, or anyone living with you have the following symptoms;	☐	☐
	- Sore throat	☐	☐
	- Cough	☐	☐
	- Shortness of breath	☐	☐
	- High temperature (38°C)	☐	☐

Medical Health Assessment

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

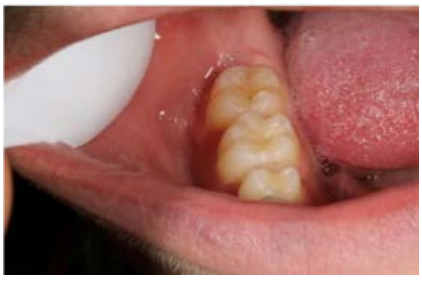
		YES	**NO**
1.	Heart murmur	☐	☐
2.	Heart attack	☐	☐
3.	Rheumatic fever	☐	☐
4.	Open heart surgery	☐	☐
5.	High blood pressure	☐	☐
6.	Stroke	☐	☐
7.	Asthma	☐	☐
8.	Chest & lung disease	☐	☐
9.	Sinus/hay fever	☐	☐
10.	Epilepsy	☐	☐
11.	Diabetes	☐	☐
12.	Kidney problems	☐	☐
13.	Gastric problems	☐	☐
14.	Depressive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

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 competed 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 3. 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?	☐	☐
2.	How has it changed since it started?	☐	☐
3.	Can you eat/drink?	☐	☐
4.	Is your swallowing or breathing affected?	☐	☐
5.	Are you taking antibiotics? If yes, please state name, dose, frequency, and since when:	☐	☐
6.	Have you taken photo(s) of the swelling? Please email to your dentist.	☐	☐

d) **Dental Trauma** (please only fill in this section if you have suffered dental trauma. Otherwise go to 3. 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 3. DENTAL PAIN)

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

Please describe the current bleeding problem:

3. DENTAL PAIN

		YES	NO
1.	Is there pain? If yes, please indicate *(tick next to)* your level of pain, 0-10 (0 = nothing and 10 = worst pain) ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10	☐	☐
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:	☐	☐

4. 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	**I CONFIRM THAT THE INFORMATION ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.** Signed by: ☐ Patient ☐ Parent ☐ Guardian *(please tick)* Name Date		