**Dental Screening Questionnaire**

**Renal Service (CKD Team)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** | [or affix sticker] | | | | | | | |
|  | | | | | | | | |
| **Date of Birth:** | |  | | | | | | |
|  | | | | | | | | |
| **Renal Diagnosis:** | | | | | | | | |
| CKD Stage 4 | | | |  | Other | | *Please specify*: | |
| CKD Stage 5  Transplanted | | | |  |  | |  | |
| **Do you have a dentist?** | | | | | | | | |
| Yes | | | |  | | If **yes**, dentist/practice name: | | |
| No | | | |  | |
| **When was the last time you had a check-up?** | | | | | | | | |
| Less than 6 months | | | | | | |  | |
| 6 - 12 months | | | | | | |  | |
| 12 - 24 months | | | | | | |  | |
| 2 years + | | | | | | |  | |
| **Do you have any of the following:** *(please tick all that apply)* | | | | | | | | |
| Bleeding gums | | | |  | | Broken teeth | |  |
| Bad breath | | | |  | | Pain / discomfort | |  |
| Dry mouth | | | |  | | Mouth ulcers | |  |
| Loose teeth | | | |  | | Other: *(details)* | |  |
| **Would you like a FREE dental check-up?** | | | | | | | | |
| Yes | | | | OR *If yes, we will contact you to arrange an appointment* | | | | |
| No | | | |  | | | | |
| **Contact details:** | | | | | | | | |
| **Address** | | |  | | | | | |
| **Phone** | | |  | | | | | |
| **Email** | | |  | | | | | |
| **Please indicate your consent for Dental Services to contact you** *(tick all that apply)* | | | | | | | | |
| By Address | | |  | | | | | |
| By Phone | | |  | | | | | |
| By Email | | |  | | | | | |
|  | | | | | | | | |