**Dental Screening Questionnaire**

**Renal Service (CKD Team)**

|  |  |
| --- | --- |
| **Name:**  | [or affix sticker] |
|  |
| **Date of Birth:** |  |
|  |
| **Renal Diagnosis:**  |
| CKD Stage 4 | [ ]  | Other  | [ ]  *Please specify*:  |
| CKD Stage 5Transplanted | [ ] [ ]  |  |  |
| **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  | [ ]  |
|  |