**Pre Expedition Dental Assessment Form**

Dear Colleague

The individual you are examining will shortly be taking part in an expedition. For an extended period of time will completely isolated from dental services. Safeguarding the overall health and well-being of expedition members in remote locations includes establishing thorough dental fitness prior to departing the UK. It is essential that all participants are dentally fit prior to travel to prevent avoidable emergencies in remote locations.

Please complete the attached form with appropriate radiographs for the patient. Your comments and the completed form will help us to determine the individual’s fitness for travel.

The individual will cover the reasonable cost of the examination, treatment and this report. He/She will be responsible for returning the report and radiographs to us. We fully understands and accepts it has no redress against you in the event of the individual encountering dental complications whilst in isolated areas but we would emphasise the importance of restoring carious lesions, removing teeth of poor prognosis or providing high quality root canal treatment where appropriate before signing the form.

We appreciate your support

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| **Patient information for assessor (completed by patient)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name |  | |  | | | | | | | | | | | Date of Birth | |  |  |  | |  | |  | | | |  | | |  | |  | |
| Telephone |  | | | | | | | | | | | | | Email | |  | | | | | | | | | | | | | | | | |
| Expedition Location | | |  | | | | | | | | | | | Dates of Expedition | |  | | | | | to | | |  | | | | | | | | |
|  | | |  | | | | | | | | | | |  | |  | | | | | | | | | |  | | | | | | |
| **Information to be completed at assessment (completed by Dentist)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Regular attender | | | | | Yes | | |  | No |  | | | Irregular attender | | | | | | Yes | | | | | |  | | | No | |  | | |
| Year of last GDP dental appt. | | | | |  | |  |  |  |  | | | | | | | | | | | | | | | | | | | | | | |
| Reason for last attendance: | | | | | Pain | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Perio. | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Fillings | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Endodontics | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Oral surgery | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Check-up | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| Other | | | | |  | | | | | | | | | | | | | | | | | | | | | | |
| **Assessment report** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Soft tissue examination | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| BPE |  |  | |  | | Active periodontal disease | | | | |  | | | | | | | | | | | | | | | | | | | | | |
|  |  | |  | |
| 3rd molars | Present | | | | | UR 8 | |  | UL8 | | |  | | | Potentially symptomatic | | | | UR 8 | | | |  | | | | UL 8 | | | | |  |
| LR 8 | |  | LL 8 | | |  | | | LR 8 | | | |  | | | | LL8 | | | | |  |

Please chart missing teeth, existing restorations, endodontically treated teeth and untreated disease if you have not been able to complete treatment you deem necessary to ensure the individual is dentally fit. **SOE or KODAK R4 PRINT OUTS WILL BE ACCEPATBLE**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
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|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| Right Left | | | | | | | | | | | | | | | | |
| 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 |  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Radiographs **attached** | B/W |  | OPT |  | P/As |  | Full mouth P/As |  | Other |  |
| Dates when taken |  |  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Treatment identified at assessment visit and completed |  | Treatment not yet completed |  |
|  |  |
|  |  |
|  |  |
| Potential areas of concern |  | | |
|  | | |
|  | | |
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|  | | |

I have thoroughly dentally examined this individual before his/her participation in the Expedition . All necessary treatment has been completed and I have identified what I believe could be potential areas of concern.

|  |  |
| --- | --- |
| **Summary** | |
| This individual has good oral health and is not expected to need routine treatment within the next  6 /12 months |  |
| This individual has oral conditions as outlined above but these conditions are not expected to need urgent/emergency treatment within the next 6 / 12 months |  |
| This individual has oral conditions as outlined above that may need urgent/emergency treatment within the next 6 / 12 months |  |

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| Additional comments (review of endodontically treated teeth, vitality tests of heavily restored or traumatised teeth, manifestations of systemic disease, etc) |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signed |  | GDC  Number |  |  |
| Dentist Name |  | Performer’s List Number |  |
| Date |  | Practice telephone number |  |

|  |
| --- |
| Practice Stamp |

**Please remember to enclose radiographs as necessary. Thank you.**