FIRST NATIONS AND INUIT HEALTH BRANCH
ORAL SCREENING RECORD (OSR)

Privacy statement

The personal information is collected, used, and disclosed in accordance with the *Privacy Act* (https://laws-lois.justice.gc.ca/eng/acts/P-21/index.html). Only the information needed to administer the Community Oral Health Services (COHS) is collected. This information serves as legal documentation for the treatment of clients, as well as for program reporting and evaluation. The authority to collect and use personal information for this purpose is derived from Section 6 of the *Department of Indigenous Services Act*. Personal information may be disclosed without consent, but only in accordance with subsection 8(2) of the *Privacy Act*. This personal information collection is described in Info Source (https://www.aadnc-aandc.gc.ca/eng/1353081939455/1353082011520) PIB HC PPU 008 and PIB HC PPU 009. Individuals have the right to access the personal information we collect and request changes to incorrect information. If you require clarification about this statement, contact our Privacy Coordinator at 819-997-8277. For more information on privacy issues and the *Privacy Act* in general, you may consult the Privacy Commissioner at 1-800-282-1376.

Screening date (YYMMDD)	Region	Code	Community	Code	Provider name (family and given name)	Provider no.

Client registration no.	Gender (M/F/X)	Birth date (YYMMDD)	Family name (Last)	Given name (First)

Health status and authorization **(check all that apply)** ▶ ☐ Signed authorization form ☐ Reviewed and updated medical history ☐ Parent/Caregiver **declines** fluoride varnish

Section 1: tooth status: dmft/DMFT and pufa/PUFA **MANDATORY DATA COLLECTION** (see instructions on reverse) ☐ No teeth present at time of screening

		55	54	53	52	51	61	62	63	64	65		
17	16	15	14	13	12	11	21	22	23	24	25	26	27
47	46	45	44	43	42	41	31	32	33	34	35	36	37
		85	84	83	82	81	71	72	73	74	75		
Sealants=		d=	m=	f=	D=	M=	F=	☐ Demineralization present		☐ Additional treatment required outside scope of COHS		☐ GA referral considered	

		55	54	53	52	51	61	62	63	64	65		
17	16	15	14	13	12	11	21	22	23	24	25	26	27
47	46	45	44	43	42	41	31	32	33	34	35	36	37
		85	84	83	82	81	71	72	73	74	75		
		p=	u=	f=	a=			P=	U=	F=	A=		

Section 2: work plan (provider/regional use only) (see instructions on reverse)

		55	54	53	52	51	61	62	63	64	65		
17	16	15	14	13	12	11	21	22	23	24	25	26	27
47	46	45	44	43	42	41	31	32	33	34	35	36	37
		85	84	83	82	81	71	72	73	74	75		

Comments

General instructions

- Complete each section in **blue or black ink**. Record information accurately and neatly within the allotted space. **Use block letters**.
- To correct a mistake, draw a solid line through the entry. **Do not use white out**.
- Teeth should be cleaned of any debris prior to screening.
- Providers should adopt a systematic approach for screening, proceeding in an orderly manner from client's upper right to left and lower left to lower right.
- The screening is conducted with 2x2 gauze, a mirror, Williams/WHO probe and a light source (LED pen light or head lamp).
- When recording dmft/DMFT and pufa/PUFA, only one score is assigned per tooth and recorded in the box corresponding to the tooth number on the odontogram.
- To score a tooth, use clinical judgement. If unsure of a tooth's status, omit recording information.
- A tooth should be considered present when > 1mm is visible (cusp tip).
- Sections of the OSR shaded in grey are for provider/regional use only, and are **not a mandatory data collection requirement** to be entered into the dental database.

Field descriptions:

- **Screening date** (YYMMDD): The date of screening in YY/MM/DD format. Example: June 3rd, 2019 is recorded as **19-06-03**.
- **Region and code**: The name of the region and its corresponding two digit region code. Example: Manitoba is recorded as **MANITOBA 04.**
- **Community and code:** The community name and its corresponding three digit band code. Example: Fort Alexander is recorded as **FORT ALEXANDER 262.**
- **Provider name (family/given name) and provider number:** The provider's legally registered Family (Last) and Given (First) name and their 9 digit provider number.
- **Client registration number**: The client's 9 or 10 digit registration number or the client's X number.
- **Gender:** The gender of the client using **M** for male, **F** for female or **X** for other or if non-identified.
- **Birth date (YYMMDD):** The client's birth date in YY/MM/DD format. Example: July 16, 2019 is recorded as **19-07-16.**
- **Family name and given name:** The client's legally registered Family (Last) and Given (First) name. Nicknames or assumed names are not permitted. Example: Robert James (Bobby) Brown is recorded as **BROWN, ROBERT J.**
- **Health status and authorization**: Indicate if the client has a signed authorization form, a reviewed and updated medical history and/ or if the parent/caregiver declines fluoride varnish applications. (Check all that apply).

Section 1: Tooth status - dmft/DMFT (Mandatory data collection)

- **No teeth present at time of screening:** Select if there are no teeth present at time of screening.
- dmft/DMFT describes the amount (prevalence) of dental caries in an individual.
- Lowercase letters are used for recording the primary dentition (dmft).
- Uppercase letters are used for recording the permanent dentition (DMFT).
- dmft and DMFT are recorded separately. Score can range from 0-20 for the primary dentition and 0-28 for the permanent dentition.
- Record dmf/DMF status for each tooth in the corresponding boxes of the odontogram.
- 8's, unerupted teeth, congenitally missing teeth, supernumerary teeth, teeth removed for orthodontics reasons, and primary teeth retained in the permanent dentition (DMFT only) are not counted when scoring dmft/DMFT.
- Teeth that have been sealed are considered sound (not recorded in the dmft/DMFT score).
- When a carious lesion or both a carious lesion **and a restoration** (temporary or permanent) are present, the tooth is recorded as **d/D**.
- When a tooth has been extracted due to caries, the tooth is recorded as **m/M**.
- When a restoration is present, or when a restoration is defective **but not decayed** (example: non-carious fracture), the tooth is recorded as **f/F**.
- After the screening is complete, record the total individual number for d,m,f and D,M,F in the corresponding boxes **below** the 1st odontogram. Each box (d/D, m/M, f/F,) should contain a numerical value, with the lowest possible number being **zero**.
- If there are **no d/D teeth identified** during your dmft/DMFT screening, **do not complete** the pufa/PUFA index.

The codes and criteria for dmft /DMFT index are as follows:

- **d/D**: obvious or visible **d**ecay, temporary restoration (ART/IST), decay present with restoration, decay present with sealant, clinical crown broken down.
- **m/M**: **m**issing (**e**xtracted) due to caries.
- **f/F**: **f**illed/restored tooth with no decay present - includes crowns, and preventive resin restorations.

Source: **https://www.mah.se/CAPP/Methods-and-Indices/for-Measurement-of-dental-diseases/for-Caries-prevalence/**

- **Sealants**: Teeth (primary or permanent) observed as having an existing sealant present at screening are recorded as “S” in the corresponding box of the odontogram - only one entry per tooth. After the screening is complete, record the total number of existing sealants present (primary and permanent) with the lowest possible number being zero in the corresponding box below the 1st odontogram.
- **Demineralization present**: Select if **a**ny tooth/teeth observed as having decalcification/pre-cavitation/white spot lesion(s). If the box is unchecked, it indicates there is no demineralization.
- **Additional treatment required outside scope of COHS**: Indicate whether additional treatment is required outside the scope of Community Oral Health Services (COHS). This does not imply that the providers themselves are doing the referral; however, the provider has considered the need for referral for the particular case. If the box is unchecked, it indicates that no additional treatment outside the scope of COHS is required.
- **GA referral considered**: Indicate whether General Anaesthetic (GA) referral has been considered. This does not imply that the providers themselves are doing the referral; however, the provider has considered the need for referral for the particular case. If the box is unchecked, it indicates that no GA referral was considered.

Section 1: Tooth status - pufa/PUFA (mandatory data collection)

- pufa/PUFA is an index used to assess the severity of decayed teeth only (**d/D**) and scores the presence of either a visible pulp, ulceration of the oral mucosa due to tooth/root fragments, a fistula or an abscess.
- If there is a lesion(s) present in the surrounding tissues that are **NOT a result of caries** (**d/D**), a pufa/PUFA score is not recorded (example - a fistula present on a tooth with a sound restoration).
- Lowercase letters are used for recording the primary dentition (pufa).
- Uppercase letters are used for the permanent dentition (PUFA).
- pufa and PUFA are recorded separately. Score can range from 0-20 for the primary dentition and 0-28 for the permanent dentition.
- Record pufa/PUFA status for each tooth identified as **d/D** in the corresponding boxes of the odontogram.
- If unsure, regarding the extent of odontogenic infection, the basic score (**p/P** for pulp involvement) is given.
- If the primary tooth and its permanent successor tooth are present and both present stages of odontogenic infection, **only the permanent** tooth is to be scored.
- After the screening is complete, record the total individual number for p,u,f,a and P,U,F,A in the corresponding boxes **below** the 2nd odontogram. Each box (p/P, u/U, f/F, a/A) should contain a numerical value, with the lowest possible number being **zero.**

The codes and criteria for pufa/PUFA index are as follows:

- **p/P**: opening of the **p**ulp chamber is visible or when the coronal tooth structures have been destroyed by the caries process and only roots or root fragments are left.
- **u/U**: **u**lceration due to trauma from sharp pieces of a tooth is recorded when sharp edges of a dislocated tooth with pulpal involvement or root fragments have caused traumatic ulceration of the surrounding soft tissues, e.g., **tongue or buccal mucosa**.
- **f/F**: **f**istula is a pus **releasing** sinus tract related to a tooth with pulpal involvement is present.
- **a/A**: **a**bscess is a pus **containing** swelling related to a tooth with pulpal involvement is present.

Source: http ://onlinelibrary.wiley.com/doi/10.1111/j.1600-0528.2009.00514.x/full

Section 2: Work plan

Provider/regional use only - **Not a mandatory data collection requirement** to be entered into the dental database.

Record teeth identified from screening to be treated with ART **(A)**, IST **(I)** and/or Sealant **(S)** in the corresponding boxes of the odontogram.

Comments: Provider/regional use only - **Not a mandatory data collection requirement** to be entered into the dental database. Include any relevant information to the screening.