

Restorative dentistry - Oral rehabilitation for HN cancer patients



Patient identifiable information

NHS or CHI number

DOB

Sex

Female

Male

Postcode

Clinical questionnaire

Does the patient have a GDP?

 Y N

Date of restorative referral

Date of DTT (MDT)

Was a restorative pre-treatment appointment booked and attended?

 Y N

Date of restorative dental assessment

Where dental extractions required?

 Y N

If yes, date of completion of dental extractions

Date of surgery

Date of start of radiotherapy

POST EXTRACTION

Was a holistic dental reconstruction incorporated into this patient's treatment plan?

 Y N

Were dental implants placed during the index surgery?

 Y N

If yes, was primary dental implant placement included as part of the virtual surgical plan carried out?

 Y N

If yes, Did this involve dental implant planning in conjunction with a restorative consultant?

 Y N

If yes, were the dental implant(s) restored by 18 months after the date of index surgery?

 Y N

If no, reason(s) (e.g. not required, not feasible, patient consent, delayed rehabilitation planned)

 Y N

POST EXTRACTION

Was a delayed oral rehabilitation provided?

 Y N

Did the patient wear a prosthesis prior to oral rehabilitation?

 Y N

What type of prosthesis was provided as part of the oral rehabilitation?

Date of definitive oral rehabilitation

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Oral Health Impact Profile (OHIP-14) Questionnaire

INSTRUCTIONS THE QUESTIONNAIRE

This questionnaire asks how troubles with your teeth, mouth or dentures may have caused problems in your daily life. We would like you to complete the questionnaire even if you have good dental health. We would like to know how often you have had each of the 14 listed problems during the LAST YEAR.

HOW TO ANSWER THE QUESTIONS

Each question on the left hand side of the page asks you about a particular dental problem. You should think about each question in turn, and circle the answer to the right of the question, to indicate how often you have had the problem during the last year.

Sources: *OHIP Development: Slade GD. Derivation and validation of a short-form oral health impact profile. Community Dentistry & Oral Epidemiology 1997; 25:284-90. OHIP Summary Scoring: Slade GD, Nuttall N, Sanders AE, Steele JG, Allen PF, Lahti S. Impacts of oral disorders in the United Kingdom and Australia. Br Dent J. 2005 Apr 23;198(8):489-93. Non-proprietary. Review articles before using as recommended by author Slade 2012*

Timeline:

The OHIP-14 is to be completed at three time points: (1) upon consent (prior to the start of treatment), (2) 18 months post-surgery and (3) 36 months post-surgery. At the 18 and 36 months FU, there are two extra questions.

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Oral Health Impact Profile (OHIP-14) Questionnaire (Baseline & FU)

HOW OFTEN have you had the problem during the last year?	Very often	Fairly often	Occasionally	Hardly ever	Never	Don't know
Have you had trouble pronouncing any words because of problems with your teeth, mouth or dentures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt that your sense of taste has worsened because of problems with your teeth, mouth or dentures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had painful aching in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you found it uncomfortable to eat any foods because of problems with your teeth, mouth or dentures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been self conscious because of your teeth, mouth or dentures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt tense because of problems with your teeth, mouth or dentures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has your diet been unsatisfactory because of problems with your teeth, mouth or dentures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had to interrupt meals because of problems with your teeth, mouth or dentures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you found it difficult to relax because of problems with your teeth, mouth or dentures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been a bit embarrassed because of problems with your teeth, mouth or dentures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been a bit irritable with other people because of problems with your teeth, mouth or dentures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had difficulty doing your usual jobs because of problems with your teeth, mouth or dentures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you felt that life in general was less satisfying because of problems with your teeth, mouth or dentures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you been totally unable to function because of problems with your teeth, mouth or dentures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Oral Health Impact Profile (OHIP-14) Questionnaire (FU only)

Do you have any ongoing treatment with a Restorative Dentistry specialist?

 Y N

Have you had a dental prosthesis/replacement teeth provided after your cancer treatment?

 Y N

Comment