**BUTE DENTAL CARE TRIAGE FORM**

Thank you for taking the time to complete this form. This will allow us to access your needs and therefore provide the most appropriate care and advice to you.

**Date**: …

**Section One: About You**

1. **Full Name:** …
2. **Date of Birth:** …
3. **Address/Current Location:** …
4. **Contact Telephone Number:** …
5. **Are you a Registered Patient of Bute Dental Care?:**

**Section Two: About your Dental Problem**

1. **Do you have any facial swelling?:**

*If you answered no, please go straight to Question 9*

1. **If yes, when did the swelling start/ has it changed?** …
2. **Please put a ‘Y’ in all of the boxes below that describe your swelling**:

**My swelling is:**

|  |  |
| --- | --- |
| On the Face |  |
| Cheek Area |  |
| Lower Jaw |  |
| Pea Sized |  |
| Grape Sized |  |
| Golf Ball Sized |  |
| Hot to Touch |  |
| Looking Red & Flushed |  |

|  |  |
| --- | --- |
| In the Mouth |  |
| Pea Sized |  |
| Grape Sized |  |
| Golf Ball Sized |  |
| Gum Area |  |
| Around the Tooth |  |
| Affecting Swallowing |  |
| Affecting Opening Mouth |  |

|  |  |
| --- | --- |
| Affecting Eye |  |

1. **Please add a ‘Y’ (for yes) in all of the boxes below that describe your dental problem**:

|  |  |
| --- | --- |
| Upper Jaw |  |
| Lower Jaw |  |
| Left Side |  |
| Right Side |  |
| Front of Mouth |  |
| Middle of Mouth |  |
| Back of Mouth |  |

|  |  |
| --- | --- |
| I am being Kept Awake |  |
| I have a Broken Tooth |  |
| A Filling has Fallen Out |  |
| I have a Hole in my Tooth |  |
| A Crown has Fallen Out |  |

|  |  |
| --- | --- |
| It is Tender |  |
| Sensitive to Hot and Cold |  |
| Sensitive to Pressure |  |
| Sensitive to Sweet Foods |  |
| Pain is Constant |  |
| Pain Comes and Goes |  |
| Pain is a Dull Ache |  |
| It is a Sharp Pain |  |
| It is a Shooting Pain |  |
| It is Throbbing |  |
| It is Pulsing |  |
| It is Bleeding |  |
| It has a funny Taste |  |
| It has a funny Smell |  |

1. **How many days have you had the problem?**...

**Section Three: About your Pain Relief**

1. **What have you taken for pain relief?**…
2. **When did you start taking pain relief?**...
3. **Have you taken Ibuprofen before?**…
4. **Please add a ‘Y’ (for yes) in all of the boxes below that describe you:**

|  |  |
| --- | --- |
| I have Stomach Problems |  |
| I am Allergic to Asprin |  |
| I am Asthmatic |  |
| I am Pregnant |  |
| I am Breast-Feeding |  |

**Section Four: About your Covid-19 Status and your General Health**

1. **Do you have a persistent cough?**: …
2. **Do you have a fever/ temperature?**: …
3. **Do you have a loss of smell/ taste?**: …
4. **Is anyone in your household currently in isolation or displaying the previous symptoms?**: …

As a next step, please save this completed Triage Form onto your computer and email it to us at [triage@butedentalcare.co.uk](mailto:triage@butedentalcare.co.uk) as soon as possible.

Thank you.

**For Professional Use Only:**

**OUTCOME**

**EMERGENCY**

**URGENT**

**ROUTINE**

**Worsening Statement**

**Appointment details**

Date:...............................................................................

Time:..............................................................................

Clinic:.............................................................................

|  |  |
| --- | --- |
| Relevant MH |  |
| Current Medication |  |
| Allergies |  |
| High Risk Group |  |
| Previous advice/  Prescription |  |
| Diagnosis and tooth |  |

**NOTES:**