

Your Special Smiles PLLC

Increasing the quality of life for adults who have special needs and geriatric patients who have limited mobility through advocacy, access to comprehensive dental care, and education.



Advocacy - Access - Education

Resident/Client's Name: _____ Date: _____

Hygienist's Recommended Daily Oral Hygiene Regimen: _____

DOH Instruments: _____

Limited Assistance Needed

This resident is thought to be a person who needs some assistance following oral hygiene regimen as recommended by their hygienist. For example can't open toothpaste, or has trouble flossing but can overall perform most oral hygiene tasks adequately.

Why this resident is considered in this category: _____

Recommendations:

What do they need help with? _____

What is the plan to promote independence but provide necessary help:

- Resident will do daily: _____

- Caregiver will do daily: _____

The above plan is an acceptable plan. This plan will be generated and re-evaluated by the hygienist at every hygiene recare visit. Caregivers, Guardians, Patients, Hygienists and Daily Oral Hygiene assistants can request a re-eval of this plan at any time.

Signatures:

Hygienist: _____ (print) : _____ (signature)

Caregiver: _____ (print) : _____ (signature)

Guardian: _____ (print) : _____ (signature)

DOH Assistant: _____ (print): _____ (signature)

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Month: _____

Date	Caregiver completed and name	Resident completed	Accessories adequate