Dental Telephone Triage Form (COVID-19)

(Pt advised unable to carry out face to face care, triage over phone only)

Clinician Name: ..... **Date and Time:** .....

Patient Details:

Name: ..... ***Address*** *(to identify closest Pharmacy)*

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DOB: ....

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Phone Number: ....

Medical History:

COVID-19

Do you have any symptoms of COVID-19?: Yes ☐ No ☐

Status

Asymptomatic/ COVID-19 –'ve ☐ COVID-19 +'ve ☐ Shielded ☐ Vulnerable Pt. ☐

RMH:

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Medication:

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Allergies: .....

Dental History:

History of Chief Complaint:

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Duration (days)	Severity (1-10)	Disturb Sleep?	Site	What Analgesia/Antibiotics already taken:
		Yes ☐ No ☐		

Triage Questions:

ACUTE EMERGENCY	Trauma/Laceration? (Also check signs of head injury)	Yes ☐	No ☐
	Facial Swelling?	Yes ☐	No ☐
	Restricted Tongue Movement?	Yes ☐	No ☐
	Difficulties breathing/swallowing/speaking?	Yes ☐	No ☐
	Trismus?	Yes ☐	No ☐
	Fever/feeling unwell? +/- Slurred speech, confusion, shivering, muscle ache, not passed urine in last 24 hours, rash	Yes ☐	No ☐
	Uncontrollable bleeding	Yes ☐	No ☐
	Oro-dental condition likely to exacerbate medical condition?	Yes ☐	No ☐
URGENT	Dental and soft tissue infection with NO swelling or Lymphs?	Yes ☐	No ☐
	Severe, uncontrolled dental/facial pain?	Yes ☐	No ☐
	Fractured teeth with pulpal exposure?	Yes ☐	No ☐
ROUTINE/SELF HELP	Mild/Moderate pain, responding to analgesia?	Yes ☐	No ☐
	Minor dental trauma?	Yes ☐	No ☐
	Loose or lost filling/crown/bridge/veneers?	Yes ☐	No ☐
	Broken denture?	Yes ☐	No ☐
	Bleeding gums?	Yes ☐	No ☐

Additional Details: .....

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Provisional Diagnosis:

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Advice/Treatment Given:

1) Emergency Referral needed? Yes ☐ No ☐: *Details:* .....
2) Analgesia Advised? Yes ☐ No ☐: *Details:* .....
3) Prescription Needed? Yes ☐ No ☐: *Details:* .....
4) Advice/ Home care given (e.g. Oral hygiene, boots/amazon filling kit): *Details:* .....

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Aftercare: Advised to call back if symptoms worsen? Yes ☐ No ☐ Follow up needed? Yes ☐ No ☐