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

Form Number: INTER 40-007E

► Complete each section.

General Information:
• Teeth should be cleaned of any debris prior to screening.
• Providers should adopt a systematic approach for screening, proceeding in an orderly manner from upper right to left and lower left to lower right.
• The screening is conducted with 2x2 gauze, a mirror, 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:

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Date (YYMMDD)</td>
<td>The date of service in YY/MM/DD format. Example: June 3rd, 2019 is recorded as 19-06-03.</td>
</tr>
<tr>
<td>Region and Code</td>
<td>The name of the region and its corresponding two digit region code. Example: Manitoba is recorded as MANITOBA 04.</td>
</tr>
<tr>
<td>Community and Code</td>
<td>The community name and its corresponding three digit band code. Example: Fort Alexander is recorded as FORT ALEXANDER 262.</td>
</tr>
<tr>
<td>Provider Name (Family/Given Name) and Provider Number</td>
<td>The provider's legally registered Family (Last) and Given (First) name and their 9 digit provider number.</td>
</tr>
<tr>
<td>Client Registration Number</td>
<td>The client's 9 or 10 digit registration number or the client's X number.</td>
</tr>
<tr>
<td>Sex</td>
<td>The sex of the client using M for male or F for female.</td>
</tr>
<tr>
<td>Birth Date (YYMMDD)</td>
<td>The client's birth date in YY/MM/DD format. Example: July 16, 2019 is recorded as 19-07-16.</td>
</tr>
<tr>
<td>Family Name and Given Name</td>
<td>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.</td>
</tr>
</tbody>
</table>
### Section 1: Tooth Status

| dmft/DMFT (Mandatory Data Collection) | • 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 dmft/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-curious 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 decay, temporary restoration (ART/IST), decay present with restoration, decay present with sealant, clinical crown broken down.  
| | • m/M: missing (extracted) due to caries  
| | • f/F: filled/restored tooth with no decay present - includes crowns, and preventive resin restorations.  
| **Demineralization present:** Any tooth/teeth observed as having decalcification/pre-cavitation/white spot lesion(s) |
### pu/fa/PUFA  
#### (Mandatory Data Collection)
- pu/fa/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 pu/fa/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 (pf/a).
- Uppercase letters are used for the permanent dentition (PUFA).
- pu/fa and PUFA are recorded separately. Score can range from 0-20 for the primary dentition and 0-28 for the permanent dentition.
- Record pu/fa/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 pu/fa/PUFA index are as follows:
- **p/P:** opening of the pulp 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:** ulceration 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:** fistula is a pus releasing sinus tract related to a tooth with pulpal involvement is present.
- **a/A:** abscess is a pus containing swelling related to a tooth with pulpal involvement is present.


### Sealants
Provider/regional use only - **Not a mandatory data collection requirement** to be entered into the dental database. 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 1st the odontogram.

### Additional treatment required outside the scope of COHS Services?
Indicate whether additional treatment is required outside the scope of Community Oral Health Services (COHS). Select Yes or No.

### 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.