

Name..... Personal nr.....

Address..... Postal address.....

Examiner.....Date.....

Diagnosis.....

Diagnosis pending investigation.....

Medication.....

Other physical or psychological health problem.....

DOCUMENTATION

- | | | | | | |
|-------------------------------------|-----------|-------------------------------------------|-----------|-------------------------------------|-----------|
| <input type="checkbox"/> Photo | year..... | <input type="checkbox"/> Study models | year..... | <input type="checkbox"/> FEES | year..... |
| <input type="checkbox"/> Radiograph | year..... | <input type="checkbox"/> Saliva test | year..... | <input type="checkbox"/> Ultrasound | year..... |
| <input type="checkbox"/> Video film | year..... | <input type="checkbox"/> Videofluoroskopi | year..... | Other..... | |

- For examination of new patient
- For examination of known patient

yes no 1. NECK/HEAD POSTURE

- 1 Reduced stability
- 2 Reduced mobility
- 3 Tone change
- 4 Other.....

2. FACE

- 1 Mask-like expression
- 2 M mentalis is overactive
- 3 Facial palsy *unilateral* *bilateral*
- 4 Cranio-facial abnormality
- 4a What?.....
- 5 Facial asymmetry
- 6 Concave facial profile
- 7 Convex facial profile
- 8 Straight facial profile
- 9 Skin changes
- 9a What?.....
- 10 Other.....

yes no 3. LIPS

- 1 Philtrum seems long
- 2 Philtrum seems short
- 3 Thickened lips
- 4 Lip cleft *unilateral* *bilateral*
- 5 Open mouth at rest
- 6 Angular rhagades
- 7 Low muscle tone in upper lip
- 8 Low muscle tone in lower lip
- 9 High muscle tone in upper lip
- 10 High muscle tone in lower lip
- 11 High muscle tone in muscle fibres round lips
- 12 Upper lip is inactive and raised
- 13 Under lip is flaccid and inactive
- 14 Corner of mouth raised
- 15 Corner of mouth lowered
- 16 Sucks/bites on upper lip
- 17 Sucks/bites on lower lip
- 18 Other oral habits
- 18a What?.....
- 19 Other.....

yes no 4. BREATHING

- 1 Mouth breathing
- 2 Difficulty in breathing
- 3 Large tonsils
- 4 Other.....

5. SPEECH

- 1 Speech difficulty
 - a No speech
 - b Very difficult to understand
 - c Difficult to understand
 - d Some unclear speech
- 2 Other.....

6. SALIVA

- 1 Dry mouth
- 2 Drooling
- 3 Other.....

7. TONGUE

- 1 Seems large
- 2 Seems small
- 3 Asymmetric
- 4 Short tongue frenulum
- 5 Tongue diastasis
- 6 Tongue impressions
- 7 Positioned between front teeth at rest
- 8 Positioned between front teeth when swallowing
- 9 Presses against lower front teeth
- 10 Presses against upper front teeth
- 11 Rests over molars
- 12 Low muscle tone in tongue
- 13 High muscle tone in tongue
- 14 Reduced mobility
- 15 Uncontrolled movement
- 16 Other.....

8. SOFT PALATE

- 1 Reduced mobility
- 2 Asymmetric
- 3 Divided uvula
- 4 Other.....

yes no 9. HARD PALATE

- 1 Cleft palate
- 2 Wide palate
- 3 Narrow palate
- 4 Pointed palate
- 5 Stepped palate
- 6 Defined rugae
- 7 Other.....

10. OCCLUSAL RELATIONSHIP

- 1 Neutral bite
- 2 Pre normal bite
- 3 Post normal bite
- 4 Upper jaw seems small
- 5 Upper jaw seems large
- 6 Lower jaw seems small
- 7 Lower jaw seems large
- 8 Deep bite without gingival contact
- 9 Deep bite with gingival contact
- 10 Frontal open bite
- 11 Molar contact only
- 12 Lateral open bite
- 13 Cross bite
- 14 Scissors bite
- 15 Jaw cleft *unilateral* *bilateral*
- 16 Misshaped occlusal plane
- 17 Frontal inversion
- 18 Edge to edge bite
- 19 Posturing forward
- 20 Over crowding
- 21 Spacing
- 22 Proclined upper incisors
- 23 Proclined lower incisors
- 24 Retroclined upper incisors
- 25 Retroclined lower incisors
- 26 Horizontal over bite ≥ 6 mm
- 27 Other.....

18. OROFACIAL TREATMENT

| Completed treatment | Ongoing treatment | Planned treatment | |
|------------------------------|----------------------------|----------------------------|-------------------------------------------------------------|
| 1 a <input type="checkbox"/> | b <input type="checkbox"/> | c <input type="checkbox"/> | Oral motor training What?..... |
| 2 a <input type="checkbox"/> | b <input type="checkbox"/> | c <input type="checkbox"/> | Palatal plate, oral screen, other What?..... |
| 3 a <input type="checkbox"/> | b <input type="checkbox"/> | c <input type="checkbox"/> | Food training What?..... |
| 4 a <input type="checkbox"/> | b <input type="checkbox"/> | c <input type="checkbox"/> | Restorative treatment What?..... |
| 5 a <input type="checkbox"/> | b <input type="checkbox"/> | c <input type="checkbox"/> | Prosthetics What?..... |
| 6 a <input type="checkbox"/> | b <input type="checkbox"/> | c <input type="checkbox"/> | Orthodontics What?..... |
| 7 a <input type="checkbox"/> | b <input type="checkbox"/> | c <input type="checkbox"/> | Surgery What?..... |
| 8 a <input type="checkbox"/> | b <input type="checkbox"/> | c <input type="checkbox"/> | Prophylactic treatment What?..... How often?..... |
| 9 a <input type="checkbox"/> | b <input type="checkbox"/> | c <input type="checkbox"/> | Other..... |

10 Which professionals are involved in the orofacial treatment?

| | | | |
|---------------------------------------------|---------------------------------------------|---------------------------------------------------|---------|
| a <input type="checkbox"/> Dentist | d <input type="checkbox"/> Logoped | h <input type="checkbox"/> Occupational therapist | Other: |
| b <input type="checkbox"/> Dental nurse | e <input type="checkbox"/> Speech therapist | i <input type="checkbox"/> Dietician | k |
| c <input type="checkbox"/> Dental hygienist | f <input type="checkbox"/> Physio therapist | j <input type="checkbox"/> Doctor | l |

19. TREATMENT RESULTS

| Deterioration | Unchanged | Improved | Satisfactory | |
|------------------------------|----------------------------|----------------------------|----------------------------|-----------------------------------|
| 1 a <input type="checkbox"/> | b <input type="checkbox"/> | c <input type="checkbox"/> | d <input type="checkbox"/> | Oral motor training |
| 2 a <input type="checkbox"/> | b <input type="checkbox"/> | c <input type="checkbox"/> | d <input type="checkbox"/> | Palatal plate, oral screen, other |
| 3 a <input type="checkbox"/> | b <input type="checkbox"/> | c <input type="checkbox"/> | d <input type="checkbox"/> | Food training |
| 4 a <input type="checkbox"/> | b <input type="checkbox"/> | c <input type="checkbox"/> | d <input type="checkbox"/> | Restorative treatment |
| 5 a <input type="checkbox"/> | b <input type="checkbox"/> | c <input type="checkbox"/> | d <input type="checkbox"/> | Prosthetics |
| 6 a <input type="checkbox"/> | b <input type="checkbox"/> | c <input type="checkbox"/> | d <input type="checkbox"/> | Orthodontics |
| 7 a <input type="checkbox"/> | b <input type="checkbox"/> | c <input type="checkbox"/> | d <input type="checkbox"/> | Surgery |
| 8 a <input type="checkbox"/> | b <input type="checkbox"/> | c <input type="checkbox"/> | d <input type="checkbox"/> | |

9 Comments.....

.....

Patient, carer or person responsible consents to this observation chart to be sent to Mun-H-Center.