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Questionnaire for person with parental responsibility

To be completed by Parents/Guardians at each 6 monthly attendance during the study period.

You and your child have very kindly agreed to participate in the trial of prevention in dental practice. The following questions will provide important information on your and your child's experience of dental services and the treatment they receive. Please take the time to fill in the short questionnaire.

SECTION 1: Pain Experienced or Treatment Received Outside Registered Dental Practice

1. During the past 6 months have you needed to take your child to a dentist other than your regular dentist because they had toothache? (This could be an out of hour's emergency dentist or clinic) **Yes** ☐ **No** ☐

IF NO PLEASE GO TO QUESTION 10, IF YES PLEASE CONTINUE WITH QUESTION 2…

2. **If Yes to Q1 -** Please provide the name and address of the dentist/clinic you attended:

3. **If Yes to Q1 -** Approximately how far did you have to travel to visit that dentist? ☐☐ (miles

4. **If Yes to Q1 -** Approximately how long did the whole journey (there and back) (h:mm) to that dentist take? ☐:☐☐

5. **If Yes to Q1 -** Approximately how much time did you/or your partner take off (h:mm) paid work to allow you to take your child to that dentist? ☐:☐☐

6. **If Yes to Q1 -** How many (if any) other children accompanied you for the dental visit on that occasion? ☐☐

7. If your child visited a dentist other than your regular dentist because they had toothache what treatment did they receive:

	Tick **one** box below
Advice and\or pain killers and\or antibiotics	
Filling	
Tooth extraction with an injection in the gum	
Tooth extraction under general anaesthetic	
Other, please specify: _____	

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8. If your child had a tooth extracted under general anaesthetic, which hospital / clinic did he or she attend

9. During the past 6 months has your child had toothache, but not bad enough to need them to go to a dentist? **Yes** ☐ **No** ☐

SECTION 2: Travel to Your Dentist

10. Approximately how far do you have to travel to visit your regular dentist? ☐☐ (miles)

11. Approximately how long does the whole journey (there and back) (h:mm) to your regular dentist usually take? ☐:☐☐

12. Did you travel by:

	Tick **one** box below
Walking	
Car	
Bus	
Train	
Other, please specify: _____	

13. Approximately how much time did you/your partner/ child's carer take off : (h:mm) paid work to allow you to take your child to the dentist? ☐ ☐☐

14. How many (if any) other children accompanied you/your partner /child's carer for a dental visit on this occasion? ☐☐

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SECTION 3: Possible Problems

15. If your child had fluoride varnish applied 6 months ago did they feel unwell at all in the week after their dental visit?

	Tick **one** box below
Not applicable or no problems to report	
My child felt unwell *(if yes please provide details in the box below)*	

Details:

16. Has your child had any medical treatment in hospital or by a GP at all during the 6months? Yes ☐ No ☐

If so please describe how many visits to the GP or outpatient department of a hospital, or how many inpatient nights were involved and provide details in the box below.

GP ☐☐ (number of visits)

Outpatient ☐☐ (number of visits)

Accident and Emergency ☐☐ (number of visits)

Inpatient days ☐☐ (number of rights)

Details:

Date form completed (dd/mm/yyyy): ☐☐ ☐☐ ☐☐☐☐