



Dental Care for Patients Taking Anticoagulants or Antiplatelet Drugs Patient Questionnaire

Thank you for taking the time to fill in this questionnaire. The Scottish Dental Clinical Effectiveness Programme (SDCEP), part of NHS Education for Scotland (NES), is developing new clinical guidance for dentists about how best to provide care for patients taking anticoagulant and antiplatelet drugs. By completing this survey you will help ensure that patients' views and experience are considered when developing the guidance.

It should take less than 15 minutes to complete this questionnaire. Some of the questions require you to tick a box, while other questions require you to write an answer in the box provided. Please be assured that your responses are completely anonymous, we cannot recognise you or your dentist from the answers you give us.

Once you complete the questionnaire please place it in the envelope provided and hand it back to the receptionist. Alternatively, if you prefer, you can complete it later and return it directly to SDCEP using the FREEPOST envelope provided. A summary of the results will be made available at www.triads.org.uk, once the survey is complete.

SECTION 1. Your views and experiences

1. Please select the anticoagulant or antiplatelet drug(s) you were taking when you last saw your dentist, from the list below. Tick all the boxes which apply.

Warfarin	<input type="checkbox"/>	Apixaban (Eliquis)	<input type="checkbox"/>	Dabigatran (Pradaxa)	<input type="checkbox"/>	Rivaroxaban (Xarelto)	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	Clopidogrel (Plavix)	<input type="checkbox"/>	Prasugrel (Efient)	<input type="checkbox"/>	Ticagrelor (Brilique)	<input type="checkbox"/>
Dipyridamole (Persantin)	<input type="checkbox"/>	Other (specify below)	<input type="checkbox"/>	Don't know	<input type="checkbox"/>	Not taking any	<input type="checkbox"/>

2. Has your GP or haematologist asked you to tell your dentist that you are taking an anticoagulant or antiplatelet drug?

Yes No Don't remember

If you answered yes, how was this advice given? Tick all the boxes which apply.

Verbally In a patient leaflet In a patient letter Don't remember

Other (specify below)

Did you tell your dentist that you are taking an anticoagulant or antiplatelet as advised?

Yes

No

Don't remember

3. How often does your dentist ask you about your medical history (i.e. illnesses or health problems)?

Every visit

Most visits

Occasional visits

Never

Don't remember

4. How often does your dentist ask you about your current medication, or changes to your medication?

Every visit

Most visits

Occasional visits

Never

Don't remember

5. To what extent do you agree with this statement:

Strongly disagree

Disagree

Agree

Strongly agree

a) I intend to visit my dentist as usual when taking an anticoagulant or antiplatelet drug.....

b) It's important to let my dentist know about the anticoagulant or antiplatelet drug I take before I receive dental treatment.....

6. Whilst taking an anticoagulant or antiplatelet drug and receiving dental treatment, are you concerned about any of the following? Tick all the boxes which apply.

I don't have any concerns

Accessing out of hours care

Bleeding

Other (specify below)

7. Please use the space below to give us any suggestions for improving the service you receive at the dentist while taking anticoagulant or antiplatelet drugs.

8. We are developing guidance on how best to care for patients taking anticoagulant or antiplatelet drugs who require dental treatment. Is there anything you would like this guidance to include for patients?

Information about out of hours	<input type="checkbox"/>	Information leaflet	<input type="checkbox"/>	Information posters	<input type="checkbox"/>	Other (specify below)	<input type="checkbox"/>
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SECTION 2. About you

We cannot recognise you or your dentist from the answers you give us.

1. Are you? Male Female

2. Please tell us your age? _____ years old

3. How often do you visit your dentist?

Every six months	<input type="checkbox"/>	Once a year	<input type="checkbox"/>	Once every two years	<input type="checkbox"/>	Less than every two years	<input type="checkbox"/>
Only when I have a problem	<input type="checkbox"/>						

Thank you for helping with this survey. Your contribution is very much appreciated.

If you would like to discuss any aspect of this questionnaire, please contact: Catalina Martin, Tel: 01382 740955, e-mail: scottishdental.cep@nes.scot.nhs.uk