STANDARDS OF PRACTICE
FOR
DENTAL PUBLIC HEALTH

Tennessee Department of Health
Community Health Services
Oral Health Services Section

Fifteenth Edition
Revised, May 2016

STANDARDS OF PRACTICE FOR DENTAL PUBLIC HEALTH

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GENERAL INFORMATION FOR PUBLIC HEALTH DENTAL CLINICS

TENNESSEE DEPARTMENT OF HEALTH
COMMUNITY HEALTH SERVICES
ORAL HEALTH SERVICES SECTION

GENERAL INFORMATION FOR PUBLIC HEALTH DENTAL CLINICS

I. PROLOGUE

The initial responsibility for instilling professional standards of care, values, and skills within dental providers resides with the professional and technical schools that provide the basic training within the profession of dentistry. Boards of dental examiners test basic clinical skills and knowledge on select procedures as dentists, hygienists and assistants present themselves for licensure and registration. Ultimately, it is individual professional integrity, supported by technical knowledge, clinical skills, and continued educational development that provides the foundation for the provision of needed dental services in a safe, effective, caring, and non-discriminatory manner.

The Oral Health Services Section of the Tennessee Department of Health is responsible for assuring that the dental care provided in public health clinics meets or exceeds existing standards in regard to quality, quantity, appropriateness, need, and safety. However, no administrative body can guarantee through quality assurance reviews that standards of care are being met on a patient-by-patient, procedure-by-procedure, or day-by-day basis. The maintenance of professional standards of care, in terms of individual provider responsibility for the quality and appropriateness of services provided to individual patients, rests with the provider. Our goal is that every provider should strive for excellence through practicing fundamentally sound dentistry at all times.

Essential to the accomplishment of the goals of the Oral Health Services Section is adherence to uniform standards of practice, accepted clinical technique, and accurate recordkeeping. The *Standards of Practice Manual* has been compiled to acquaint dental care providers employed in the public sector in Tennessee with the various clinical regulations, policies, recommendations, procedures, and forms used by the Oral Health Services Section. The *Standards of Practice Manual* serves as a reference source regarding policies and procedures of the Oral Health Services Section.

In addition to this manual, dental staff in public health clinics in Tennessee must adhere to the guidelines and regulations presented in two companion manuals: *Exposure Control Manual for Dental Health Care Workers* and *Hazard Communication Program for Public Health Dental Clinics*. Every public health dental clinic in Tennessee should have access to the aforementioned manuals for easy reference, and they should be made available to all personnel involved in the delivery of dental care in a public health setting. Revisions, additions, and deletions will be made to these manuals when necessary to keep current with new or revised standards. Up-to-date revisions of the Standards of Practice Manual are also available online here.

II. ADMINISTRATIVE AND INTERDISCIPLINARY RELATIONS

Dentists, dental hygienists, and dental assistants working in dental public health clinics in Tennessee must be licensed or registered to practice dentistry, dental hygiene, or dental

assisting. The Dental Practice Act, for scope of practice, for any of the above mentioned professionals may be found in TCA Title 63. The dentist, dental hygienist, and dental assistant are responsible for fees (registration, license renewal, or privilege taxes) imposed by the State of Tennessee to keep all licenses or registrations current throughout the period of employment with the state. A dentist who prescribes scheduled narcotics in the course of patient treatment must have a current, unrestricted DEA number.

All persons employed in dental public health in Tennessee should be familiar with the *Tennessee Dental Practice Act* and *Rules of the Tennessee Board of Dentistry* and strictly adhere to all regulations regarding dental practice, professional conduct, utilization of auxiliaries, etc. The most current revisions of these two documents are available online at the Tennessee Board of Dentistry.

All rules, regulations, and policies promulgated by the State of Tennessee, the Department of Health, the Community Health Services (CHS), and the appropriate local authorities will be followed. These rules include: attendance and leave procedures, work hours (including time of arrival and departure), proper dress code, and other rules as set forth by the supervising authority. Job performance planning, interim work reviews and employee performance evaluation will be completed at the proper intervals. Interaction and communication with supervisors and support personnel will be conducted at appropriate intervals and in a professional manner. Collegiality with other health care providers within the department is encouraged, and in-house referrals should be made when appropriate.

The normal workday consists of 7.5 hours. It is recommended that each full-time clinician have at least 2,400 patient contacts per year, which translates into treatment of a minimum of ten (10) patients per day with twenty five (25) Relative Value Unit's (RVU) per day.

III. LEVELS OF DENTAL SERVICE

The purpose of this section is to outline the Oral Health Services guidelines regarding levels of service and provision of care by dental providers working within the framework of the Tennessee Department of Health.

A. Level I – Emergency Dental Services

All public health dental clinics should provide for treatment of adult dental emergencies and other populations as identified by the Department of Health. Dental emergency treatment is limited to diagnosis and treatment of an acute episode of pain, infection, swelling, hemorrhage, or trauma (i.e., relief of pain and suffering). These may include extractions and/or prescription medications.

B. Level II – Primary Prevention

All public health dental clinics should provide primary preventive services appropriate for the target population. Suggested primary preventive dental services include:

1. Oral Health Education
    a) Oral hygiene instruction
    b) Dietary counseling
    c) Trauma prevention – bicycle helmets, seat belts/child restraints and mouth guards
    d) Fluoride effectiveness
    e) Oral cancer prevention

2. Prophylaxis
3. Topical application of fluoride varnish
4. Supplemental fluoride therapy (tablets or drops) as indicated
    a) Community water fluoridation assessment
    b) Individual well water analysis
    c) Adherence to current supplemental fluoride dosage schedule
    d) Physicals, medical examinations, and dental examinations should incorporate oral cancer detection and prevention principles
5. Pit and fissure sealants

C. Level III – Basic Dental Services

Services that primarily control or eliminate oral diseases (e.g., dental caries, gingivitis, and periodontitis) should be provided. Examples include:

1. Comprehensive oral diagnostic procedures
2. Restorative dental procedures
3. Basic endodontic procedures
4. Basic periodontal procedures
5. Basic oral surgery procedures

D. Level IV – Rehabilitative Dental Services

Services that primarily restore oral structure may be provided. Examples include:

1. Removable prosthetic services
2. Fixed prosthetic services

E. Remote Supervision of Hygienists

The following protocol is in response to the amended language of the Dental Practice Act effective July 1, 2013. TCA 63-5-109 adding subsections (15) and (16). Click here for access to TCA 63-5-109.

Definition:

Remote supervision – a Tennessee Department of Health (TDH) dentist has regular, periodic communications with a TDH dental hygienist regarding patient treatment, without requiring an evaluation by a dentist prior to application of a dental sealant or application of topical fluoride.

Management:

Program guidance and quality assurance shall be provided by Oral Health Services Section in the Community Services Division of the Tennessee Department of Health for public health dentists providing supervision under this protocol. Guidance for all TDH dental hygienists providing services through remote supervision is outlined below:

- TDH annual training by the public health dentist will include didactic and on-site components utilizing evidence based protocols, procedures and standards from the Standards of Practice Manual for Dental Public Health and the School Based Dental Prevention Program Manual.
- TDH monitoring by the public health dentist during remote supervision activities shall include tracking locations of planned service delivery and review of reports of services provided. Phone or personal communication between the public health dentist and the dental hygienist will occur at a minimum of every 14 days.
- TDH monitoring by public health dentist of each hygienist during remote supervision will include at least semi-annually on-site visits with completion of all categories of Quality Assurance review checklist at each visit.
- No limit shall be placed on the number of full or part time TDH dental hygienists that may practice under the remote supervision of a public health dentist.

Remote Supervision Practice Requirements:

The dental hygienist shall have a current unrestricted Tennessee dental hygiene license and provide services in a Tennessee Department of health public health dental program or Metropolitan Health Department program.

Scope of Services:

- Provide educational services
- Conduct needs assessment and referral for all children with unmet dental needs
- Assess patients to determine appropriateness of sealant placement according to TDH Oral Health Services guidelines and apply sealants as indicated
- Chart teeth eligible for sealants and teeth sealed
- Application of topical fluoride varnish
- Participate in data collection activities and surveys as needed

IV. LEGAL ASPECTS OF TREATING MINORS

Written consent for treatment must be obtained for each patient prior to an examination or any subsequent treatment. This policy is relatively straightforward when adults present themselves for treatment at a public health facility, yet the majority of patients treated in most of our public health dental clinics are minors. The question that needs to be addressed is "When can a minor authorize or consent to any medical (dental) services?"

In 1993, Patricia L. Newton, Assistant General Counsel for the Tennessee Department of Health, rendered the following legal opinion regarding authorization and consent to medical

or dental care for minors. This opinion is based on CARDWELL v. BECHTOL (Tenn. 1987) 724 S.W. 2d 739.

- A minor fourteen (14) years of age or older is presumed to be competent to authorize and consent to medical services offered by the health departments. The presumption is rebuttable and the determination of competency is a medical decision based upon the trained professional evaluation of the health care provider. Complete documentation of the decision making process is advised.
- A minor aged seven (7) through thirteen (13) years is presumed to be incompetent to authorize and consent to medical services offered by the health departments. The presumption is rebuttable and the determination of competency is a medical (nursing) (dental) decision based upon the trained professional evaluation of the health care provider.
- A minor under the age of seven (7) years is conclusively presumed to be incompetent to authorize and consent to medical services offered by the health departments. The presumption is not rebuttable and the determination of competency is not a medical (nursing) (dental) decision based upon the trained professional evaluation of the health care provider.
- A minor/teenage parent has the authority and duty to provide/obtain health care services for their children as well.

Note: It is the responsibility of each clinic to determine protocol regarding parents/guardians present in the treatment room with the child. This protocol must be clearly stated to the parent/guardian at the initial visit. This policy **must be posted** and be clearly visible in the reception area of the dental clinic.

V. DENTAL PATIENT RECORDS

It is necessary that we standardize the dental patient records that are being used in our dental public health clinics across the state. The *Clinic Oral Evaluation and Treatment Record* (PH-0205A) and the *Health History for Dental Services* (PH-3990) or the appropriate *Electronic Record* ***must*** be utilized in all dental public health clinics in all regions.

It is essential that we have complete and accurate records on all patients. Therefore, when admitting new patients, we are asking the dentist to ensure that the dental staff completes all sections of the dental patient record including the medical history, consent for treatment, charting of the examination and treatment, and thoroughly documents all services delivered to patients. The most current version of all forms will be utilized in the clinic. The specific criteria and standards for public health dental records are delineated in the *Quality Assurance Review Instruments for the Direct Observation of Public Health Dental Practice* (refer to Section 3).

There must be a dental patient record for each individual seen in the clinic regardless of level of care being provided or payment source. **Every dental patient must have a complete, accurate, and up-to-date *Clinic Oral Evaluation and Treatment Record* (PH-0205A) and**

a *Health History for Dental Services* (PH-3990) or appropriate Electronic Record as part of his or her dental record.
In the area of recordkeeping, much of the information (e.g., patient identification, medical history, and charting) will be obtained or recorded by the dental assistant or clerical personnel. Standardized Charting **MUST** be used in all Rural Public Health Dental Clinics. The Metro Health Departments will follow Metro Policy for charting. Examples of the standardized charting are included in Section 2 of this manual, along with descriptions of the charting symbols. However, treatment entries (progress notes) are the responsibility of the dentist, and all pertinent patient information should be reviewed and signed by the dentist to ensure that it is correct, current, and complete.

Confidentiality of patient records and treatment is the "cornerstone" of building trust in a doctor-patient relationship. This confidentiality must never be compromised. The policies and procedures regarding confidentiality expressed in CHS Policy 5.2 are strictly enforced. Failure to maintain confidentiality of patient records may result in disciplinary actions up to and including termination of the employee. Each clinic and its professionals must be HIPAA compliant.

The policies and procedures regarding Retention and Destruction of Records are found in CHS Policy 5.3.a. Following is the policy for retaining records:

- Medical records, to include dental, must be retained by the health department for ten (10) years following the last date of service (i.e. if the last date of service was April 25, 2007 then the record must be retained until April 25, 2017).
- The medical record of a minor or person with a mental disability must be retained for the period of minority (under 18 years of age) or mental disability, plus one (1) year or ten (10) years following the last date of service, whichever is longer.

    - ❖ If a seventeen (17) year olds last date of service was May 1, 2007 then the record must be retained until May 1, 2017.
    - ❖ If a seven (7) year olds last date of service was May 1, 2007 then the record must be retained until May 1, 2019.
    - ❖ If a person with a mental disability continues to have a mental disability then the record cannot be disposed of, but if the person becomes better, the above guidelines will be followed.

Key identification information such as: name, gender, birth date, address, record number, and TennCare number (when applicable) must be present. A consent form or permission for treatment must be obtained from the patient, parent, or the patient's guardian before treatment is started. **It is required that a new medical history and signed consent form be completed for each patient annually**. Update the patient's medical history at each visit, on the *Health History of Dental Services Form* (PH-3990) or in the progress note; document the date and any changes. Written informed consent ***must*** be obtained prior to performing any oral surgery procedure using *Informed Consent for Oral & Maxillofacial Surgery* (PH-3432). If the patient has taken an Oral Bisphosphonate drug, then the *Informed Consent for Patients Taking Oral Bisphosphonates* (PH-4035) must be completed as well. If the patient has no

previous history of taking Oral Bisphosphonates only the Informed Consent for Oral & Maxillofacial Surgery (PH-3432) needs to be completed.

As our dental clinics are focusing more on adult dental emergency care, there is the possibility of encountering more individuals on bisphosphonates and therefore more individuals at risk for Bisphosphonate Related Osteonecrosis of the Jaw (BRONJ) post-extraction. In order to provide guidance to the dental clinical staff and to provide the highest quality care to our patient population, the health history has been revised (PH-3990) and specifically asks (question 15) about medications to treat osteoporosis or osteopenia.

A. Individuals who have taken an oral bisphosphonate for less than three years and have no clinical risk factors, no alteration or delay in the planned surgery is necessary. This includes any and all surgeries common to oral and maxillofacial surgeons and other dental providers.
    1. The following factors are thought to be risk factors for BRONJ:
    2. Corticosteroid therapy
        a) Diabetes
        b) Smoking
        c) Alcohol use
        d) Poor oral hygiene
        e) Chemotherapeutic drugs

B. Individuals who have taken an oral bisphosphonate for less than three (3) years and have also taken corticosteroids concomitantly.

C. Individuals who have taken an oral bisphosphonate for more than three (3) years with or without any concomitant prednisone or other steroid medication.

D. Individuals who are being treated with IV bisphosphonates for hypercalcemia, bone metastases and other conditions.

The following guidelines, concerning extractions for this patient population, have been reviewed and approved by Central Office Oral Health Services as well as the rural regional dental directors. This policy is based on recommendations from the American Association of Oral and Maxillofacial Surgeons, the American Dental Association, and the University of Tennessee, School of Dentistry.

Patient Categories:

1. Type I – Extractions can be performed on this classification of patient but the decision to treat is up to the individual dental provider's professional judgment-Bisphosphonate informed consent is required in addition to informed consent for oral surgery.
2. Type II – To be referred to an oral surgeon for extraction.
3. Type III – To be referred to an oral surgeon for extraction.
4. Type IV – To be referred to an oral surgeon for extraction.

The Health History for Dental Services Form must be completed for each patient who is treated in a public health dental clinic. All health questions ***must*** be answered. Any medications or allergies must be noted. The health history must be dated and signed by the patient or parent/guardian ***and*** the dentist. **Any medical condition that could affect dental treatment should be noted on the record treatment page, and flagged using a sticker for med alerts, or an annotation is made using red ink. These stickers or annotations in red ink should be placed on the *Clinic Oral Evaluation and Treatment Record* and on the *Health History Form*.** The health history must be updated at every visit and any change noted on the PH-3990 or in the progress note.

An accurate and complete medical history is a prerequisite to patient treatment. Since information obtained from patients, parents, or guardians is subjective, it can never be assured that all responses are accurate. Pertinent information may be unreported. A well-structured medical history together with appropriate follow-up to key responses should give the baseline patient data on which determinations are made concerning referrals, patient management, treatment planning, and treatment.

A dental history should be taken on every patient and should include: 1) problems with or reactions to anesthesia, 2) specific complaint(s), and 3) problems with previous dental treatment. Existing oral conditions including restorations, caries, periodontal status, oral hygiene status, and any other pertinent observations will be recorded for all patients undergoing comprehensive or preventive care. Complete charting of the oral examination and treatment rendered for each patient is imperative. A chief complaint should be noted for every patient.

Appropriate radiographs as determined by the dentist as necessary for diagnosis or treatment should be labeled, dated, **mounted (if film)** and maintained or electronically stored as part of the patient's record. Dental radiographic images are maintained as part of the dental record until the record can be destroyed according to CHS Policy 5.3.a. It is recommended that the type and quantity of radiographs be based on the following guidelines:

- Following the ALARA Principle (As Low as Reasonable Achievable) to minimize patient's exposure. See table on page 5 of ADA's Radiographic Recommendations
- Initial radiographs for an adult patient should consist of individualized images including bitewings with panoramic exam or bitewings and selected periapicals. A full-mouth intraoral radiographic examination is appropriate when the patient presents with clinical evidence of generalized dental disease or extensive dental treatment.
- For children with primary teeth only, radiographs are made if the proximal surfaces of the primary teeth cannot be visualized or if there are specific problems.
- For children with a transitional dentition or adolescent with permanent dentition, initial radiographs should consist of posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.
- Recall bitewing radiographs should be made at a frequency based on caries activity, caries risk, disease activity, or specific problems.
- Recall panoramic radiographs for children with transitional dentition should be based on clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth & development. For adolescents

with permanent dentition the recommendation is based on clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth & development.

X-Ray Inspections are required every four (4) years. Scatter radiation is not routinely checked during inspections, but a scatter radiation monitoring test can be conducted if there is a concern about the amount of scatter radiation being emitted. Contact the Department of Environment and Conservation, Division of Radiological Health, in your area to request this test. Radiation Dosimetry badges are not required due to insignificant amount of scatter radiation, but if a dentist or assistant becomes pregnant or if an employee requests a dosimetry badge, the employer should purchase one for the employee.

All CHS Policies can be found online here.

Parents/guardians must be notified in those cases where there may be an alternate treatment (such as a root canal) to a non-reversible procedure (such as an extraction), and when the alternate procedure for any reason cannot be accomplished in the public health dental clinic. The parent/guardian should be offered the opportunity to seek treatment at an alternate source. Referral for treatment should be documented in the patient's record. If the parent elects the non-reversible procedure offered at the public health clinic, written informed consent for that procedure must be obtained.

Diagnosis and treatment of a condition shall be charted, using standardized charting symbols and a written entry made in the record. Progress notes must include tooth number, diagnosis, and a complete description of the procedure including materials used, and type and quantity of anesthetic given. All prescriptions and pre-op or post-op medications dispensed or used should be recorded including name of drug, quantity, and dosage. All canceled or broken appointments should be noted in the record and initialed by the appropriate person.

Progress notes must be legible using blue or black ink. Each entry must be dated and signed (using signature on Legal Signature Page) by the provider, using proper credentials i.e. DDS, RDH or RDA. Identifying patient information must be included on all forms. Errors must not be corrected with white out. A line should be drawn through the mistake to avoid the impression that a record may have been altered. Write CID (Correction in Documentation) immediately above the mistake, then initial and date if different from date of original entry.

A signed medical history and written consent for treatment will be obtained for each patient.

VI. TREATMENT FACILITY

The dental public health clinic should be located in a facility that provides for adequately sized clinical operatories, adequate heating and cooling, and proper lighting to provide dental treatment in optimal conditions. It is the responsibility of the dentist to assure that the public health dental clinic is maintained in a manner that provides dental staff and patients with a

clean and orderly place to work and receive dental care. The dentist is responsible for assuring that the clinic has the necessary equipment and supplies.

VII. EMERGENCY PROTOCOL AND EQUIPMENT

Every dental public health clinic must have a written protocol for management of medical emergencies (refer to Section 4). Every dental clinic must be equipped with or have ready accessibility to an emergency kit containing devices and drugs per CHS Policy 3.4.a and that the dentist is trained to use to support life in an emergency situation. A separate medical emergency kit for the dental clinic is only necessary if the dental clinic is on a separate floor or in a separate building from the medical clinic and the health department emergency kit. The dentist should communicate on a regular basis with the appropriate medical personnel (nursing director and/or health officer) to assure that the dental emergency kit (if necessary) is maintained with drugs that are "in-date". Each facility must be equipped with oxygen that can be delivered under positive pressure. Every dentist, dental hygienist, and dental assistant must maintain current certification in CPR throughout the course of employment.

VIII. QUALITY ASSURANCE REVIEW

The Oral Health Services Section Quality Assurance Review Program is designed to provide an effective, objective, and uniform method of evaluating clinical dental services to assure that high quality care is provided to all patients in a professional manner. The quality assurance review process is part of the Professional Standards Board process and an essential component of the employee's annual job performance cycle (i.e., job planning discussion, interim reviews, and job performance evaluation). The Oral Health Services Section with regional input has developed a quality assurance review instrument for dentists who deliver direct patient care in health department settings (refer to Section 3). The purpose of this process is to assess and improve the quality of dental care delivered to health department patients. The professional competency of dentists is assessed by chart review and by direct observation of clinical care by the Regional Dental Director. Regional QI staff will conduct administrative, availability, and risk minimization review for all dental clinics.

All dentists who deliver direct patient care in health department settings are to be reviewed at least annually. New dentists must be reviewed within the first eight (8) weeks of employment to include Dental Record Review and Direct Observation of Care (Section 3). Upon completion of the review, the Initial Professional Performance Evaluation (IPPE) of the Professional Standards Board must be completed by the Regional Dental Director. Both sections of the QA review will be conducted at the eight (8) week interval and at the annual review of all newly employed dentists. After successful completion of these initial reviews, record review only can be conducted every other year at the discretion of the regional dental director. Regional dental directors are responsible for reviewing all sections of the Quality Assurance Review, for all dentists providing direct patient care in the health departments in their region.

The record review portion of the Quality Assurance must be done by the Regional Dental Director or designee of the State Dental Director. During the record review portion of the

Quality Assurance Review process, a minimum of **twenty (20)** patient records ***must*** be reviewed, from the previous twelve months. Records that are reviewed can be used only one (1) time in the record review section. These records are not to be used in the Direct Observation of Care Section. This will ensure a review of the comprehensive care provided by the dentist (under review). When doing the Record Review, a note must be placed in the progress notes of the chart stating that you have reviewed this chart.

Example: Date, Record Reviewed for QA, your signature, as shown on the Legal Signature Page, with credentials, (DDS).

During the Direct Observation of Patient Care, a notation must also be made in the progress note section of the chart.

Example: Date, Record used for Direct Observation of Patient Care for QA, your signature, as shown on the Legal Signature Page, with credentials, (DDS).

There is evidence that a relationship exists between the quality of clinical record keeping and the quality of care provided. Therefore, the focus of the quality assurance review program will be on the evaluation of the dental records of individual patients as well as the direct clinical observation of care.

To assure that dentist quality assurance review evaluations are completed as required by CHS Policy 3.1.b, this review process will be monitored statewide by the Oral Health Services Section. The "centralization" of dental quality assurance review should result in evaluations that are completed in an accurate and timely manner for all dentists providing direct patient care in public health facilities.

The regional dental director has the responsibility of assuring that necessary corrective action is taken to bring the evaluated dentist into compliance with the quality assurance criteria and standards of practice for public health dentistry. The template for a corrective plan of action is found in Section 2 – Dental Clinical Public Health Forms. Besides improving individual performance, the findings from the quality assurance evaluations will be used to target specific areas of public health dental practice for discussion at future field staff meetings and continuing education programs.

IX. GENERAL TREATMENT INFORMATION

A. Efforts should be made to provide pertinent and accurate information to parents and children concerning their role in the maintenance of good oral health. Each patient should be given home care instruction to include oral hygiene care and dietary information.

B. Treatment of dental caries and major esthetic defects should be given the highest priority after relief of pain and infection. Treatment should follow a logical sequence. Normally, with minor variations, this is:
   1. Relief of pain and suffering

2. Elimination of infection and traumatic conditions
3. Caries control (removal of soft, deep caries)
4. Prophylaxis, preventive procedures, and oral hygiene instruction
5. Endodontic therapy
6. Periodontal therapy
7. Extractions
8. Restoration of teeth
9. Replacement of teeth
10. Placement of the patient on an individualized recall schedule

C. Preventive and restorative dentistry should be emphasized rather than extractions unless there is no alternative.

D. Conduction block or infiltration anesthesia should be used whenever indicated during operative procedures to control pain and should always be used for extractions.

E. A child should not be physically restrained or forced to accept treatment. If reasonable persuasion or use of inhalation conscious sedation does not result in the cooperation of the child, it is suggested that the child be referred to a pediatric dentist for treatment.

F. Respect for and awareness of the dignity of all patients should be an integral part of all interactions between patients and dental staff.

G. Accurate records must be kept in order to have available data on each patient's dental needs, treatment rendered, and the effectiveness of the overall program.

H. Protective eyewear is required for all patients during treatment.

X. EMERGENCY SERVICES

Dental emergency treatment is limited to diagnosis and treatment of an acute episode of pain, infection, swelling, hemorrhage, or trauma (i.e., relief of pain and suffering). These may include extractions and/or prescription medications. Patients admitted to the clinic with a dental emergency should be treated by the most efficacious method. If the tooth is restorable and restorative procedures cannot be accomplished at the time of the emergency appointment, palliative care should be rendered and the patient scheduled for additional treatment. The progress notes in the dental record should reflect the fact that the patient presented to the clinic with an emergency condition, and the diagnosis and treatment rendered should be described in detail.

In *no* instance should a patient be sent home or referred without any measures taken to relieve his/her distress.

Public health dental clinics should operate on an appointment system. Scheduled appointments should have priority over routine type dental emergencies. In general, parents should accompany all minors to the dental clinic and be available in the reception area.

Because of manpower, resource, and time limitations only an emergency examination and treatment of the emergency condition should be performed at the emergency visit. Patients who qualify for additional comprehensive dental care should be scheduled for dental treatment at the public health facility.
A sufficient number of appropriate radiographs should be ordered and interpreted by the dentist. A periapical radiograph of diagnostic quality (i.e., adequate area of observation and proper density, contrast, and detail) ***must*** be made prior to extracting any tooth (except in the case of primary teeth near exfoliation). A current diagnostic quality radiograph of must be made prior to extraction of any permanent tooth. If the patient rejects radiographs recommended by the dentist, written confirmation to this effect must be made on the patient's record.

The emergency condition of the patient should be treated according to acceptable dental practice. The emergency condition should be treated by the most appropriate method as time allows. The following guidelines apply to emergency treatment.

A. If the tooth can be restored, but time does not allow for a permanent restoration, a temporary or sedative treatment filling (calcium hydroxide and IRM) can be placed after removal of the gross caries.

B. If root canal therapy or a pulpotomy is indicated, initial endodontic treatment should be performed to relieve pain. The patient should be scheduled to return in five to seven days for continued treatment.

C. Patients with acute conditions that negate the ability to achieve adequate local anesthesia should receive palliative treatment and scheduled for more definitive treatment when the acute conditions subside.

D. Appropriate antibiotics and/or analgesics are dispensed or prescribed if necessary.

E. If the emergency is complex and is beyond the ability of the dentist or outside the facility's scope of treatment, the dentist should arrange referral to other appropriate dental treatment sources.

XI. DIAGNOSTIC SERVICES

A proper diagnosis consists of the patient's state of oral health and the existence of any pathology or abnormal condition including the causes and type of pathology or condition. The primary diagnostic tools are the dental history, medical history, radiographs, and clinical examination. The dentist is responsible for obtaining adequate medical and dental histories for each patient. The medical history must be updated at each appointment and any change noted on the PH-3990. Medical **conditions** or **medications** requiring an alert must be flagged**, using appropriate sticker or an annotation made in red pen on** the **Health**

History for Dental Services and Clinic Oral Evaluation and Treatment Record to indicate medical alert. Any condition that may affect dental treatment is to be noted on the treatment page. If there is a question or compromising condition, the patient's physician should be consulted.
TDH will follow current American Heart Association guidance concerning the need for and medications used for prophylactic coverage of dental treatment.
A thorough intraoral examination of the hard and soft tissues and extraoral examination of the head and neck must be performed on all initial care patients. An abbreviated oral and extra-oral examination must be performed on all emergency patients. Bitewing radiographs supplemented with a sufficient number of appropriate periapical image or panoramic radiographs for the proposed treatment are required prior to treating any patient. All patients should be properly shielded with a lead apron and thyroid collar when radiographs are taken. If radiographs are not indicated or refused by the patient, the reason should be recorded on the patient's record.

A treatment plan must be developed for every patient undergoing comprehensive care. Examination findings for each tooth and its defective surface(s) must be recorded on the patient record. A systematic approach to treatment by mouth quadrants should be utilized with the objectives of completing necessary dentistry in the fewest number of patient visits. For example, if treatment is needed on the lower right quadrant for a permanent molar, second primary molar and first primary molar, block anesthesia may enable the dentist to perform necessary treatment of all three teeth at one visit.

XII. PREVENTIVE SERVICES

Ideally, dental prophylaxis, pit and fissure sealants, oral hygiene instruction, application of fluoride varnish, diagnostic radiographs, and examination charting are performed prior to providing restorative treatment. This is not always possible due to the magnitude or severity of disease frequently seen in public health settings, and therefore, some patients may receive restorative treatment on their first visit.

The majority (≥90 percent) of dental caries in the permanent dentition of school-aged children is located in pits and fissures. Numerous clinical studies have demonstrated that sealants are a safe and long-term method of preventing pit and fissure caries. The use of dental sealants is a logical approach for further improvement in children's oral health.

Pit and fissure sealants should be applied routinely in public health dental clinics. Indications for sealants include:

- Recently erupted teeth with well-defined morphology,
- individual history of past caries experience, and
- Children at high risk for developing caries.

Some patients having pit and fissure caries are indicated for sealants and, when appropriate, dental providers should place sealants over incipient lesions. Studies specifically designed to measure caries progression under small sealed lesions have shown minimal or no caries progression. It is recommended that staff place sealants over incipient caries confined to the

enamel because it is extremely effective in arresting this type of decay; it conserves tooth structure; and it is reversible. Sealants used to treat caries are referred to as therapeutic sealants.

If there is no gross oral hygiene problem or periodontal disease the dentist should perform the operative procedures necessary to complete the patient's treatment. If a patient has no restorative or surgical needs, a prophylaxis should be done to complete the treatment.

When prescribed and used appropriately, fluoride supplements provide benefits similar to those obtained from ingesting optimally fluoridated water over the same period of time. When improperly prescribed, fluoride supplements may cause **mild** enamel fluorosis. Therefore, systemic fluoride supplements should never be prescribed to children in fluoridated communities who are receiving optimally fluoridated water (0.7 ppm fluoride).

Because of an increase in the milder forms of dental fluorosis associated with fluoride ingestion in excess of that necessary to prevent tooth decay, a conservative approach to fluoride supplementation should be used in accordance with the revised guidelines listed below. If a child's primary drinking water source is a well, spring, or non-fluoridated community water system, a water sample must first be taken and analyzed to determine the fluoride content and the dosage of fluoride supplement needed, if any.

The American Dental Association, American Academy of Pediatric Dentists, and the American Academy of Pediatrics jointly established guidance on fluoride supplementation for children and the information is available on their respective websites.

XIII. RESTORATIVE SERVICES

The practice of "watching" or "observing" a small carious lesion is no longer acceptable with the exception of an asymptomatic, carious primary tooth near exfoliation. As stated previously, dental sealants should be applied to teeth with pit and fissure enamel defects and incipient carious lesions.

All restorations reproduce sound tooth contours.

XIV. ENDODONTIC SERVICES

Pulpotomies should be performed when possible in order to prevent the premature loss of primary teeth. Teeth that have had pulpotomies should be protected when possible with a stainless steel crown.

Endodontics can be provided in the public health clinic if resources are available.

XV. PERIODONTIC SERVICES

If there are oral hygiene problems, gingivitis, or periodontal disease, the dentist should inform the patient, parent, or guardian and provide the necessary treatment (full mouth

periodontal charting, scaling, root planing and curettage, prophylaxis, and oral hygiene instruction), if possible. Moderate and severe periodontal disease should be referred to the periodontist.

XVI. ORAL SURGERY SERVICES

Teeth that cannot be successfully restored should be extracted or referred for extraction. Deciduous teeth that are indicated for extraction ***and*** are near exfoliation, asymptomatic, and causing no apparent pathology can be allowed to remain for space maintenance. Third molars that are indicated for surgical extraction (complete bony, partial bony or soft tissue impactions) should be referred for extraction.

When any tooth is extracted, all portions of the tooth should be removed, except under circumstances where injury to the surrounding hard and/or soft tissues is likely to occur with further attempts at retrieval. If it is necessary to leave a root tip, the patient should be informed; treatment options including referral should be discussed; and all pertinent information should be documented in the patient's record.

A radiograph of diagnostic quality (i.e., adequate area of observation and proper density, contrast, and detail) *must* be made prior to extracting any tooth (except in the case of primary teeth near exfoliation).

If the patient rejects radiographs recommended by the dentist, written confirmation to this effect must be made in the patient's record.

Written informed consent ***must*** be obtained prior to performing **any** oral surgery procedure using *Informed Consent for Oral & Maxillofacial Surgery* (PH-3432). If the patient has taken an Oral Bisphosphonate drug, then the *Informed Consent for Patients Taking Oral Bisphosphonates* (PH-4035) must be completed as well. If the patient has no previous history of taking Oral Bisphosphonates only the *Informed Consent for Oral & Maxillofacial Surgery* (PH-3432) needs to be completed.

Following oral surgery, all patients must be given oral post-operative instructions in addition to written post-operative instructions. These instructions must be documented in the patient's chart as follows: Oral & Written Post-op Instructions given to patient. Thorough documentation in the dental record of the oral surgery procedure(s), complications, quantity and type of anesthetic, post-operative instructions, medication(s), and referrals must be completed by the dentist after all oral surgery.

XVII. REFERRALS

At a minimum, dental public health facilities should provide comprehensive oral diagnosis, oral disease preventive services, and routine dental treatment for children and emergency dental treatment for adults. However, it is recognized that uncooperative children will need to be referred on occasion to pediatric dentists. Also, referrals should be made for services

not offered in the dental facility. All referrals for medical/dental consultation or treatment must be documented in the patient's dental record.

XVIII. PATIENT RECALL

Each patient undergoing routine dental care should be placed on recall based on the individual patient's needs, or at least once annually. The customary recall period is six months after the last preventive visit unless special conditions exist that indicate a need for a more frequent recall schedule.

SECTION 2

DENTAL CLINICAL PUBLIC HEALTH FORMS

TENNESSEE DEPARTMENT OF HEALTH
COMMUNITY HEALTH SERVICES
ORAL HEALTH SERVICES SECTION

Dental Clinical Public Health Forms and Internal Use Forms

- Health History for Dental Services (PH-3990) – This is a double sided form with English on one side, Spanish on other side
- Health History for Dental Services, Spanish (PH-3990) – See note above
- "Clinic" Oral Health and Treatment Record (PH-0205A)
- Standardized Charting Examples & Instructions for Charting
- Caries Risk Assessment
- Periodontal Charting Record (PH-3970)
- Periodontal PSR, Examples and Instructions
- Dental Examination and Operative Record (PH-0205B)
- Informed Consent for Oral & Maxillofacial Surgery, English (PH-3432) – This is a double sided form with English on one side, Spanish on other side
- Informed Consent for Oral & Maxillofacial Surgery, Spanish (PH-3432) – See note above
- Informed Consent for Oral Surgery in Patients Who Have Received Oral Bisphosphonate Drugs, English (PH-4035) – This is a double sided form with English on one side, Spanish on other side
- Consent for Surgery for Oral Bisphosphonates, Spanish (PH-4035S) – See note above
- What To Do After Extraction of a Tooth, English (DH-0064) – This is a double sided form with English on one side, Spanish on other side
- What To Do After Extraction of a Tooth, Spanish (DH-0064) – See note above
- Dental Encounter Form (PH-3626)
- Autoclave and Spore Test Log
- Waterline Treatment and Monitoring Form
- Clinical Competency Checklist for Dental Assistants 1
- Clinical Competency Checklist for Dental Assistants 2
- Improvement Plan of Action Form
- Reporting Attempts to Unlawfully Obtain Controlled Substances

HEALTH HISTORY FOR DENTAL SERVICES

Fill out in blue or black ink only.

Patient's Name: _____ / /
F rs Middle Last Nickname Date of Birth Age Child's Social Security Number

Home Address: _____
Street City Zip Code Telephone Number Cell Number

School: _____

Date MM/DD/YR	Any Changes Yes	No			
/ /			/ /	/ /	
/ /			/ /	/ /	

1. What is the reason for your visit today?

2. Has there been any change in your health within the past year? Yes No

3. Are you under the care of a physician? ..... Yes No
   Explain

4. The name and address of my physician is:

5. Have you had any serious illness or operation? Yes No
   If so, what was the illness or operation?

6. Do you use any kind of tobacco? Yes No

7. Do you have or have you had the following diseases or problems?
   a. ADHD ..... Yes No
   b. Arthritis ..... Yes No
   c. Artificial joints (hip/knee replacements) ..... Yes No
   d. Asthma ..... Yes No
   e. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke, heart murmur) ..... Yes No
   f. Congenital heart lesions ..... Yes No
   g. Diabetes ..... Yes No
   h. Fainting spells or seizures ..... Yes No
   i. Hay fever ..... Yes No
   j. Hepatitis, jaundice or liver disease ..... Yes No
   k. Human immunodeficiency virus (HIV/AIDS) Yes No
   l. Low blood pressure ..... Yes No
   m. Psychiatric or psychological counseling ..... Yes No
   n. Rheumatic fever or rheumatic heart disease ..... Yes No
   o. Substance abuse (alcohol, drugs) ..... Yes No
   p. Tuberculosis ..... Yes No
   q. Venereal disease Yes No
   r.

9. Have you ever had a serious injury to the head, face or jaw? ..... Yes No
   If so, please explain:

10. Are you taking any over the counter drugs? Yes No
    If so, please list

11. Have you ever had abnormal bleeding associated with previous extractions, surgery or trauma? ..... Yes No
    a. Have you ever had a blood transfusion? ..... Yes No
    b. Do you have a blood clotting disorder? ..... Yes No
    If so, please explain:

12. Have you ever had radiation therapy or chemotherapy? ..... Yes No

13. Are you taking any of the following?
    a. Antibiotics or sulfa drugs.. Yes No
    b. Anticoagulants (blood thinners) Yes No
    c. Medication for high blood pressure ..... Yes No
    d. Cortisone (steroids) Yes No
    e. Tranquilizers Yes No
    f. Aspirin Yes No
    g. Insulin, tollbutamide (Orinase) or like drug Yes No
    h. Digitalis or drugs for heart condition Yes No
    i. Nitroglycerin ..... Yes No
    j. List all current medications _____

14. Are you allergic to or have you reacted adversely to?
    a. Local anesthetics ..... Yes No
    b. Penicillin ..... Yes No
    c. Other antibiotics, specify
    d. Sulfa drugs ..... Yes No
    e. Barbiturates, sedatives or sleeping pills Yes No
    f. Aspirin Yes No
    g. Iodine ..... Yes No
    h. Codeine ..... Yes No
    i. Latex ..... Yes No
    j. Nickel Yes No
    k. Other

15. Have you taken any medications (Fosomax, Boniva, Actonel) for Osteoporosis or Osteopenia (brittle bones) Yes No
    If so, please list: _____

16. Do you have any disease, condition or problem not listed above? Yes No
    If so, please explain:

17. Have you used Methamphetamine, Cocaine etc. within the last 48 hours? ..... Yes No

WOMEN

18. Are you pregnant? ... Yes No
19. Are you taking birth control pills? ..... Yes No

STATEMENT OF CONSENT FOR HEALTH SERVICES

I hereby give my consent to all visits necessary for _____ to receive an oral evaluation, dental treatment, follow-up and maintenance treatment, transportation for these services, and for the release of information of health conditions to official agencies and/or private doctors. To the best of my knowledge, the foregoing medical history questions have been accurately answered. I have been given a copy of the Department of Health's Notice of Privacy Practices.

Patient/Parent or Guardian Name: (please print)
Patient/Parent or Guardian Signature:
In Case of Emergency, please notify: Phone (_____)
Dentist Signature:

PH-3990

RDA 150

HISTORIA CLÍNICA DE SERVICIOS DENTALES

Llenar con tinta azul o negra.

Nombre del paciente: _____ / / _____
Nombre | Segundo nombre | Apellido | Sobrenombre | Fecha de nacimiento | Edad | Número de seguro social del menor

Dirección: _____ ( ) _____ ( ) _____
Calle | Ciudad | Cód. postal | Teléfono | Teléfono celular

Escuela: _____

Actualiz. historia clínica	Fecha MM/DD/AA	Cambios Sí	No	Fecha MM/DD/AA	Cambios Sí	No	Fecha MM/DD/AA	Cambios Sí	No	Fecha MM/DD/AA	Cambios Sí	No
	/ /			/ /			/ /			/ /		
	/ /			/ /			/ /			/ /		

1. ¿Cuál es el motivo de esta consulta?
_____
_____

2. ¿Han ocurrido cambios en su estado de salud en el último año? Sí No

3. ¿Recibe cuidado médico actualmente? ..... Sí No
Detalles: _____
_____

4. Nombre y dirección de su médico:
_____
_____

5. ¿Se ha sometido a una operación o ha padecido una enfermedad grave? .. Sí No
En caso afirmativo, describa la enfermedad u operación _____
_____
_____

6. ¿Utiliza algún tipo de tabaco? ..... Sí No

7. ¿Padece o ha padecido alguno de los siguientes problemas o enfermedades?
a. ADHD ..... Sí No
b. Artritis ..... Sí No
c. Articulaciones artificiales (reemplazos de cadera o rodilla) ..... Sí No
d. Asma ..... Sí No
e. Enfermedad cardiovascular (problemas o ataques cardíacos, insuficiencia u oclusión coronaria, presión arterial elevada, arteriosclerosis, accidente cerebrovascular, soplo cardíaco) .. Sí No
f. Lesiones cardíacas congénitas ..... Sí No
g. Diabetes ..... Sí No
h. Desmayos o convulsiones ..... Sí No
i. Fiebre del heno ..... Sí No
j. Hepatitis, ictericia o enfermedad hepática ..... Sí No
k. Virus de inmunodeficiencia humano (VIH/SIDA) ..... Sí No
l. Presión arterial baja ..... Sí No
m. Consultas psiquiátricas o psicológicas ..... Sí No
n. Fiebre reumática o cardiopatía reumática ..... Sí No
o. Abuso de sustancias (alcohol, drogas) ..... Sí No
p. Tuberculosis ..... Sí No
q. Enfermedad venérea ..... Sí No
r. Otro _____

9. ¿Ha sufrido alguna lesión grave en la cabeza, cara o mandíbula? ... Sí No
Detalles: _____
_____

10. ¿Toma medicamentos de venta libre? ..... Sí No
Lista de medicamentos: _____
_____

11. ¿Alguna vez ha sangrado anormalmente debido a extracciones cirugías o traumas previos? ..... Sí No
a. ¿Alguna vez le han hecho una transfusión sanguínea? ..... Sí No
b. ¿Padece de algún desorden de coagulación sanguínea? .. Sí No
Detalles: _____
_____

12. ¿Alguna vez se ha sometido a terapia de radiación o quimioterapia? ..... Sí No

13. ¿Toma alguno de los siguientes medicamentos?
a. Antibióticos o sulfamidas ..... Sí No
b. Anticoagulantes (diluyentes sanguíneos) ..... Sí No
c. Medicamentos para la presión arterial elevada ..... Sí No
d. Cortisona (esteroides) ..... Sí No
e. Tranquilizantes ..... Sí No
f. Aspirina ..... Sí No
g. Insulina, tolbutamida (Orinase) o medicamentos similares Sí No
h. Digitalis o medicamentos para problemas cardíacos ..... Sí No
i. Nitroglicerina ..... Sí No
j. Lista de medicamentos que toma _____
_____

14. ¿Es alérgico o ha reaccionado adversamente a lo siguiente?
a. Anestésicos locales ..... Sí No
b. Penicilina ..... Sí No
c. Otros antibióticos, especificar _____
d. Sulfamidas ..... Sí No
e. Barbitúricos, sedantes o pastillas para dormir ..... Sí No
f. Aspirina ..... Sí No
g. Iodo ..... Sí No
h. Codeína ..... Sí No
i. Látex ..... Sí No
j. Níquel ..... Sí No
k. Otros _____

15. Ha tomado medicamentos (Fosomax, Boniva, Actonel) para la osteoporosis u osteopenia (fragilidad ósea) ..... Sí No
Lista de medicamentos: _____
_____

16. ¿Padece de alguna enfermedad, condición o problema no especificado arriba? ..... Sí No
Detalles: _____
_____

17. ¿Ha usado metanfetaminas, cocaína etc. en las últimas 48 horas? .. Sí No

MUJERES

18. ¿Está embarazada? ..... Sí No
19. ¿Toma píldoras anticonceptivas? ..... Sí No

DECLARACIÓN DE CONSENTIMIENTO PARA RECIBIR CUIDADO MÉDICO

Mediante la presente autorizo todas las consultas necesarias para que _____ reciba evaluaciones orales, tratamientos dentales, tratamientos de seguimiento y mantenimiento, transporte para obtener dichos servicios, y para que su información de salud sea divulgada a entidades oficiales y/o a médicos privados. Conforme a mi leal saber y entender, he respondido verazmente las preguntas realizadas en la presente sobre mi historia clínica. Se me ha entregado una copia de la Notificación sobre prácticas de privacidad del Departamento de Salud (Department of Health's Notice of Privacy Practices).

Nombre del paciente, pariente o tutor: (letra de molde) _____
Firma del paciente, pariente o tutor: _____ **Fecha:** _____
En caso de emergencia llamar a: _____ **Teléfono (_____)** _____
Firma del dentista: _____ **Fecha:** _____

PH-3990 RDA 150

Tennessee Department of Health - Oral Health Services
"Clinic" Oral Evaluation and Treatment Record

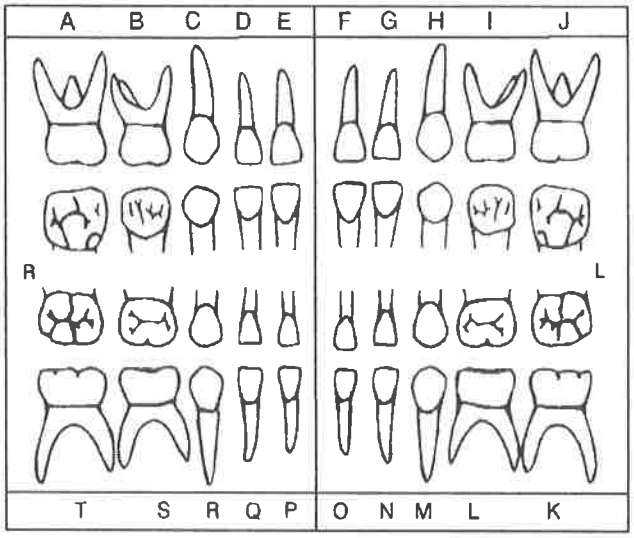
Name: _____
(First) (Middle) (Last)

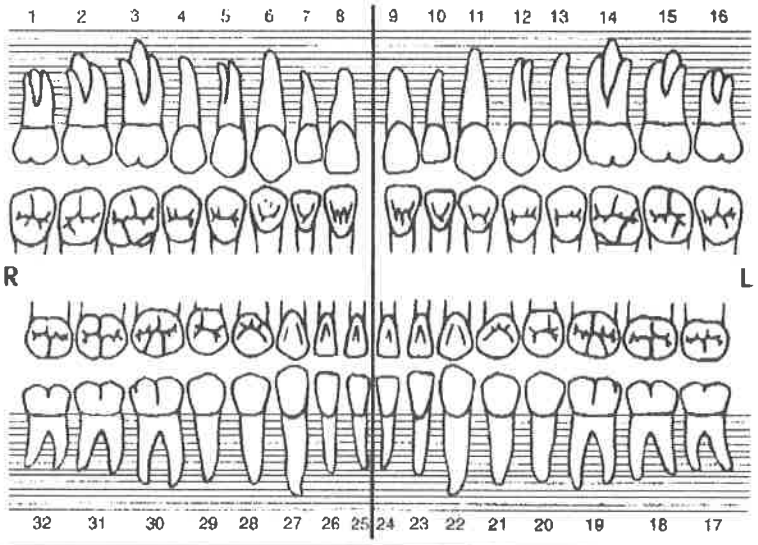
Affix Label

Medical Alert _____
Exam Date _____

TREATMENT PLAN					
Tooth	Treatment	Tooth	Treatment	Tooth	Treatment

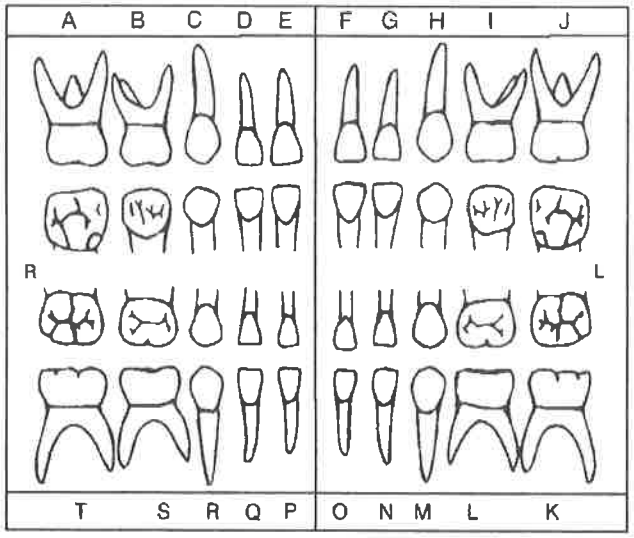
Existing Conditions

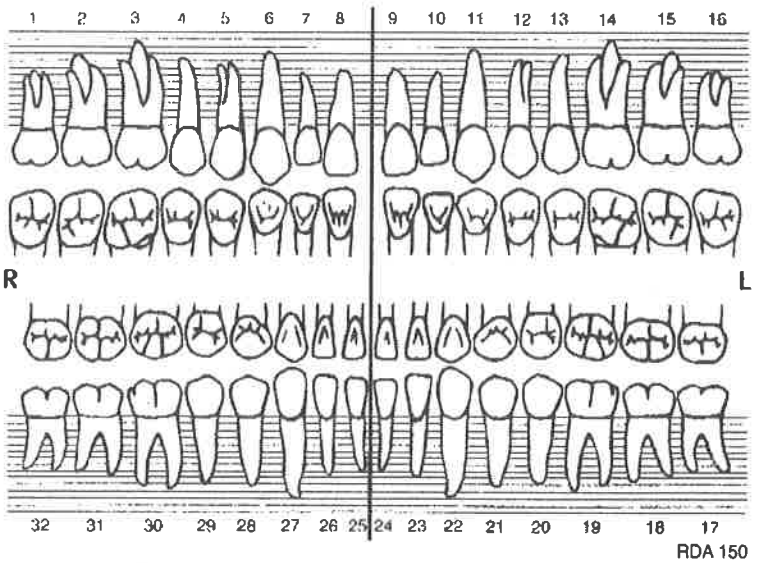




		Exam (D0120), **Caries Present:** ☐ Yes ☐ No	Signature / Title
		Caries Status: ☐ Incipient ☐ Moderate ☐ Severe	(Full Name)
		Restorations Present: ☐ Yes ☐ No **Defective:** ☐ Yes ☐ No	
		Oral Hygiene: ☐ Poor ☐ Fair ☐ Good	
		Soft Tissue Status: ☐ Within normal limits ☐ Abnormal	
		Oral Cancer Screening: ☐ Within normal limit ☐ Abnormal	
		Occlusion: ☐ Normal ☐ Malocclusion **Ortho Class:** ☐ I ☐ II ☐ III	
		Malocclusion: ☐ Cross-bite ☐ Overbite ☐ Overjet	
		☐ Over-retained teeth ☐ Crowding	
		Comments:	

Treatment Rendered





Name: _____

TREATMENT PLAN					
Tooth	Treatment	Tooth	Treatment	Tooth	Treatment

TREATMENT PLAN					
Tooth	Treatment	Tooth	Treatment	Tooth	Treatment

Exam Date _____ Medical Alert _____

Existing Conditions

		Exam (D0120), **Caries Present:** ☐ Yes ☐ No	
		Caries Status: ☐ Incipient ☐ Moderate ☐ Severe	Signature / Title
		Restorations Present: ☐ Yes ☐ No **Defective:** ☐ Yes ☐ No	(Full Name)
		Oral Hygiene: ☐ Poor ☐ Fair ☐ Good	
		Soft Tissue Status: ☐ Within normal limits ☐ Abnormal	
		Oral Cancer Screening: ☐ Within normal limit ☐ Abnormal	
		Occlusion: ☐ Normal ☐ Malocclusion **Ortho Class:** ☐ I ☐ II ☐ III	
		Malocclusion: ☐ Cross-bite ☐ Overbite ☐ Overjet	
		☐ Over-retained teeth ☐ Crowding	
		Comments:	

Treatment Rendered

SAMPLE

Tennessee Department of Health - Oral Health Services
"Clinic" Oral Evaluation and Treatment Record

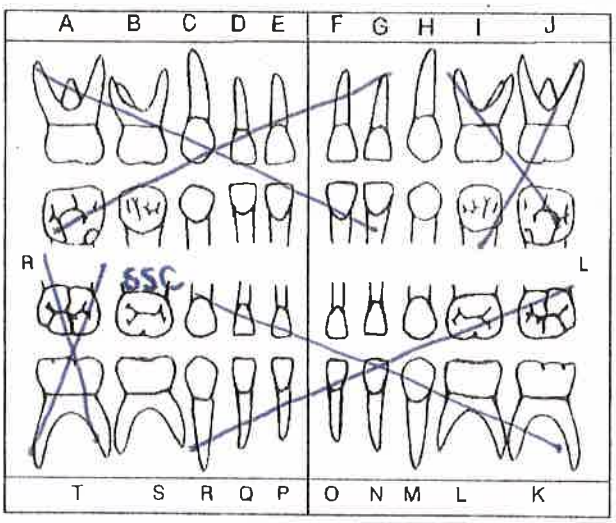
Name: _____
(First) (Middle) (Last)

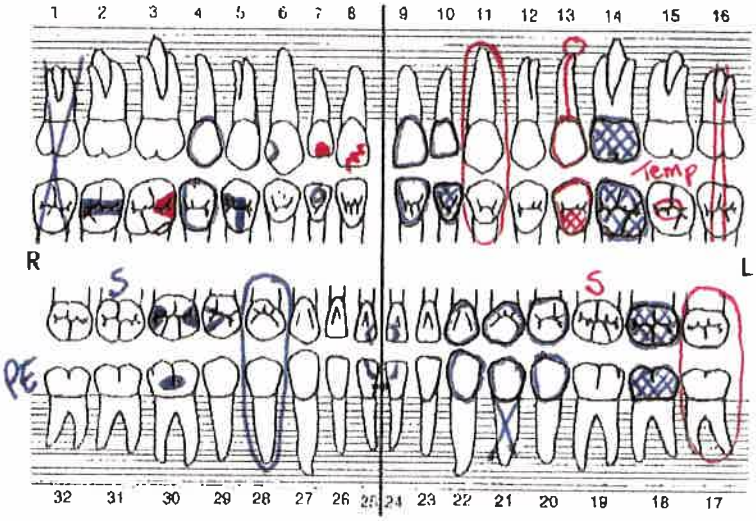
Affix Label

Medical Alert _____
Exam Date _____

TREATMENT PLAN					
Tooth	Treatment	Tooth	Treatment	Tooth	Treatment

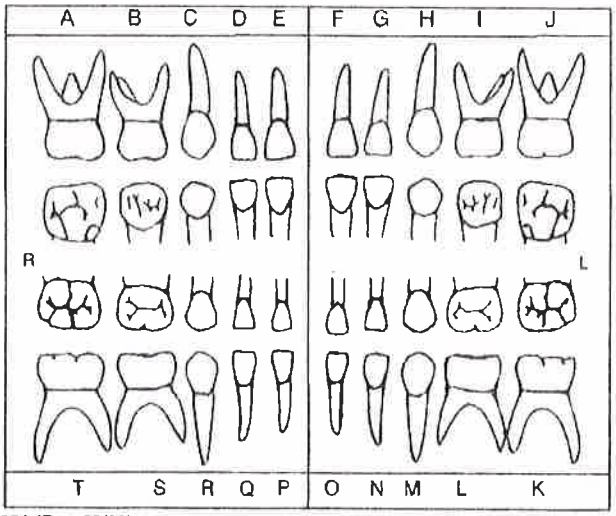
Existing Conditions

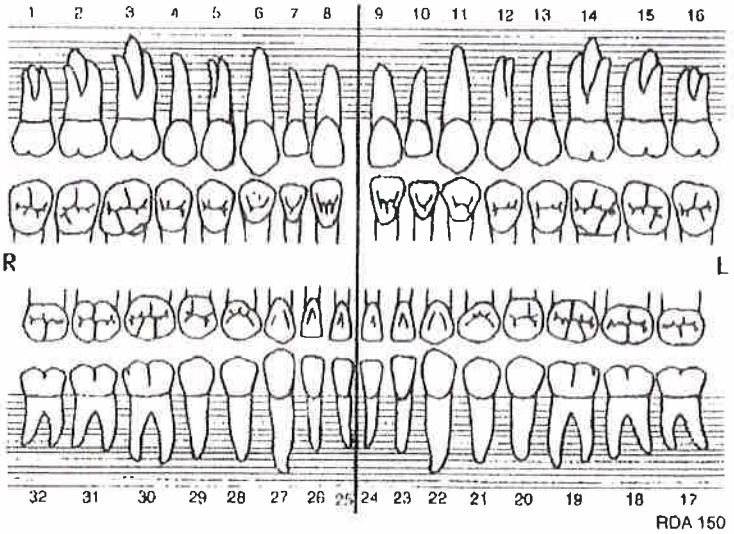




		Exam (D0120). Caries Present: ☐ Yes ☐ No	Signature / Title (Full Name)
		Caries Status: ☐ Incipient ☐ Moderate ☐ Severe	
		Restorations Present: ☐ Yes ☐ No Defective: ☐ Yes ☐ No	
		Oral Hygiene: ☐ Poor ☐ Fair ☐ Good	
		Soft Tissue Status: ☐ Within normal limits ☐ Abnormal	
		Oral Cancer Screening: ☐ Within normal limit ☐ Abnormal	
		Occlusion: ☐ Normal ☐ Malocclusion Ortho Class: ☐ I ☐ II ☐ III	
		Malocclusion: ☐ Cross-bite ☐ Overbite ☐ Overjet	
		☐ Over-retained teeth ☐ Crowding	
		Comments:	

Treatment Rendered





PH-0205A (Rev. 02/08)

RDA 150

STANDARDIZED CHARTING

Dental Charting

Below is a list of tooth numbers and documented findings for each tooth listed. Note that each example given has been correctly charted on form PH0205A, and is included for your reference immediately following this example list.

TOOTH NUMBER	FINDING(S)/TREATMENT
Tooth # 1 –	Missing Tooth X
Teeth # A-G, I, J, K-R –	Missing Teeth – X through tooth grid
Tooth # 2 –	MOD Amalgam
Tooth # 3 –	MO Caries – Solid red
Tooth # 4 –	All Ceramic Crown – Outline tooth in blue
Tooth # 5 –	DOL – Amalgam – Solid blue
Tooth # 6 –	DF – Composite – Outline in blue
Tooth # 7 –	L – Composite & Red if Caries
Tooth # 8 –	MIF Fracture
Tooth # 9 –	All Ceramic Crown – Outline tooth in blue
Tooth # 10 –	PFM Crown – Outline facial and cross-hatch lingual and distal areas
Tooth # 11 –	Retained Deciduous Tooth (H), in service rendered area indicate H is retained and status of #11 if known – either missing or impacted
Tooth # 13 –	Abscessed Tooth, needs a root canal, PFM Crown – Outline facial and cross-hatch lingual and distal areas
Tooth # 14 –	Gold Crown – Cross-hatch crown of tooth grid
Tooth # 15 –	Temporary Restoration – draw area on tooth where temp is located, write "Temp" next to tooth
Tooth # 16 –	Recommended for Extraction – draw (l l; parallel lines) through tooth grid
Tooth # 17 –	Impacted Tooth – Circle tooth grid in red
Tooth # 18 –	Gold Crown – Cross-hatch marks
Tooth # 19 –	Sealant needed, S can be placed directly above, below or on the tooth surface
Tooth # 20 –	Bridge Abutment – Cast Alloy – cross-hatch crown of tooth
Tooth # 21 –	Bridge Pontic – All Ceramic, missing – Outline tooth, place an X on root of tooth grid
Tooth # 22 –	Bridge Abutment – Cast Alloy – cross-hatch crown of tooth
Tooth #24 –	Mesial, Facial, Lingual composite splinted to #25 – draw line between 24-25
Tooth #25 –	Mesial, Facial, Lingual composite splinted to #24 – draw line between 24-25
Tooth #S –	SSC – write SSC next to tooth in blue if completed, in red if needed
Tooth # T –	Missing – Place blue X through tooth grid
Tooth # 28 –	Un-erupted Tooth – Circle tooth grid
Teeth # 29 –	DO – Composite
Tooth # 30 –	M & D Amalgam with a separate Buccal amalgam
Tooth # 31 –	Sealant placed, S can be placed directly above, below or on the tooth surface
Tooth # 32 –	Partially Erupted Tooth – write PE next to tooth

Descriptions:

1. X – Missing teeth, teeth not present at time of exam, to include lost deciduous teeth.
2. Place an X through the center of the tooth grid of all missing teeth.
3. Retained Deciduous Teeth – In service rendered area annotate that H is retained and the status of the permanent tooth if known, i.e. Impacted or missing
4. Partially Erupted applies to all teeth that are partially erupted.
5. In service rendered area:
    a. Annotate any space maintainers such as band & loop, or lingual arch permanent retainers.
    b. Reseals and Implants will also be annotated in this area.

Treatment needed – charted using red
Treatment complete – charted using blue
Existing conditions – charted using blue

ADA American Dental Association®
America's leading advocate for oral health

Caries Risk Assessment Form (Age 0-6)

Patient Name:				
Birth Date:			**Date:**	
Age:			**Initials:**	
		Low Risk	**Moderate Risk**	**High Risk**
Contributing Conditions		**Check or Circle the conditions that apply**		
I.	**Fluoride Exposure** (through drinking water, supplements, professional applications, toothpaste)	☐ Yes	☐ No	
II.	**Sugary Foods or Drinks** (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Primarily at mealtimes ☐	Frequent or prolonged between meal exposures/day ☐	Bottle or sippy cup with anything other than water at bed time ☐
III.	**Eligible for Government Programs** (WIC, Head Start, Medicaid or SCHIP)	☐ No		☐ Yes
IV.	**Caries Experience of Mother, Caregiver and/or other Siblings**	No carious lesions in last 24 months ☐	Carious lesions in last 7-23 months ☐	Carious lesions in last 6 months ☐
V.	**Dental Home**: established patient of record in a dental office	☐ Yes	☐ No	
General Health Conditions		**Check or Circle the conditions that apply**		
I.	**Special Health Care Needs** (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)	☐ No		☐ Yes
Clinical Conditions		**Check or Circle the conditions that apply**		
I.	**Visual or Radiographically Evident Restorations/ Cavitated Carious Lesions**	No new carious lesions or restorations in last 24 months ☐		Carious lesions or restorations in last 24 months ☐
II.	**Non-cavitated** (incipient) **Carious Lesions**	No new lesions in last 24 months ☐		New lesions in last 24 months ☐
III.	**Teeth Missing Due to Caries**	☐ No		☐ Yes
IV.	**Visible Plaque**	☐ No	☐ Yes	
V.	**Dental/Orthodontic Appliances Present** (fixed or removable)	☐ No	☐ Yes	
VI.	**Salivary Flow**	Visually adequate ☐		Visually inadequate ☐

Overall assessment of dental caries risk: ☐ Low ☐ Moderate ☐ High

Instructions for Caregiver:

Caries Risk Assessment Form (Age 0-6)

Circle or check the boxes of the conditions that apply. Low Risk = only conditions in "Low Risk" column present; Moderate Risk = only conditions in "Low" and/or "Moderate Risk" columns present; High Risk = one or more conditions in the "High Risk" column present.

The clinical judgment of the dentist may justify a change of the patient's risk level (increased or decreased) based on review of this form and other pertinent information. For example, missing teeth may not be regarded as high risk for a follow up patient; or other risk factors not listed may be present.

The assessment cannot address every aspect of a patient's health, and should not be used as a replacement for the dentist's inquiry and judgment. Additional or more focused assessment may be appropriate for patients with specific health concerns. As with other forms, this assessment may be only a starting point for evaluating the patient's health status.

This is a tool provided for the use of ADA members. It is based on the opinion of experts who utilized the most up-to-date scientific information available. The ADA plans to periodically update this tool based on: 1) member feedback regarding its usefulness, and; 2) advances in science. ADA member-users are encouraged to share their opinions regarding this tool with the Council on Dental Practice.

ADA American Dental Association®
America's leading advocate for oral health

Caries Risk Assessment Form (Age >6)

Patient Name:			
Birth Date:		**Date:**	
Age:		**Initials:**	

		Low Risk	Moderate Risk	High Risk
Contributing Conditions		Check or Circle the conditions that apply		
I.	**Fluoride Exposure** (through drinking water, supplements, professional applications, toothpaste)	☐ Yes	☐ No	
II.	**Sugary Foods or Drinks** (including juice, carbonated or non-carbonated soft drinks, energy drinks, medicinal syrups)	Primarily at mealtimes ☐		Frequent or prolonged between meal exposures/day ☐
III.	**Caries Experience of Mother, Caregiver and/or other Siblings** (for patients ages 6-14)	No carious lesions in last 24 months ☐	Carious lesions in last 7-23 months ☐	Carious lesions in last 6 months ☐
IV.	**Dental Home**: established patient of record, receiving regular dental care in a dental office	☐ Yes	☐ No	
General Health Conditions		Check or Circle the conditions that apply		
I.	**Special Health Care Needs** (developmental, physical, medical or mental disabilities that prevent or limit performance of adequate oral health care by themselves or caregivers)	☐ No	Yes (over age 14) ☐	Yes (ages 6-14) ☐
II.	**Chemo/Radiation Therapy**	☐ No		☐ Yes
III.	**Eating Disorders**	☐ No	☐ Yes	
IV.	**Medications that Reduce Salivary Flow**	☐ No	☐ Yes	
V.	**Drug/Alcohol Abuse**	☐ No	☐ Yes	
Clinical Conditions		Check or Circle the conditions that apply		
I.	**Cavitated or Non-Cavitated** (incipient) **Carious Lesions or Restorations** (visually or radiographically evident)	No new carious lesions or restorations in last 36 months ☐	1 or 2 new carious lesions or restorations in last 36 months ☐	3 or more carious lesions or restorations in last 36 months ☐
II.	**Teeth Missing Due to Caries in past 36 months**	☐ No		☐ Yes
III.	**Visible Plaque**	☐ No	☐ Yes	
IV.	**Unusual Tooth Morphology** that compromises oral hygiene	☐ No	☐ Yes	
V.	**Interproximal Restorations - 1 or more**	☐ No	☐ Yes	
VI.	**Exposed Root Surfaces** Present	☐ No	☐ Yes	
VII.	**Restorations with Overhangs** and/or **Open Margins**; **Open Contacts** with Food Impaction	☐ No	☐ Yes	
VIII.	**Dental/Orthodontic Appliances** (fixed or removable)	☐ No	☐ Yes	
IX.	**Severe Dry Mouth (Xerostomia)**	☐ No		☐ Yes

Overall assessment of dental caries risk: ☐ Low ☐ Moderate ☐ High

Patient Instructions:

Caries Risk Assessment Form (Age >6)

Circle or check the boxes of the conditions that apply. Low Risk = only conditions in "Low Risk" column present; Moderate Risk = only conditions in "Low" and/or "Moderate Risk" columns present; High Risk = one or more conditions in the "High Risk" column present.

The clinical judgment of the dentist may justify a change of the patient's risk level (increased or decreased) based on review of this form and other pertinent information. For example, missing teeth may not be regarded as high risk for a follow up patient; or other risk factors not listed may be present.

The assessment cannot address every aspect of a patient's health, and should not be used as a replacement for the dentist's inquiry and judgment. Additional or more focused assessment may be appropriate for patients with specific health concerns. As with other forms, this assessment may be only a starting point for evaluating the patient's health status.

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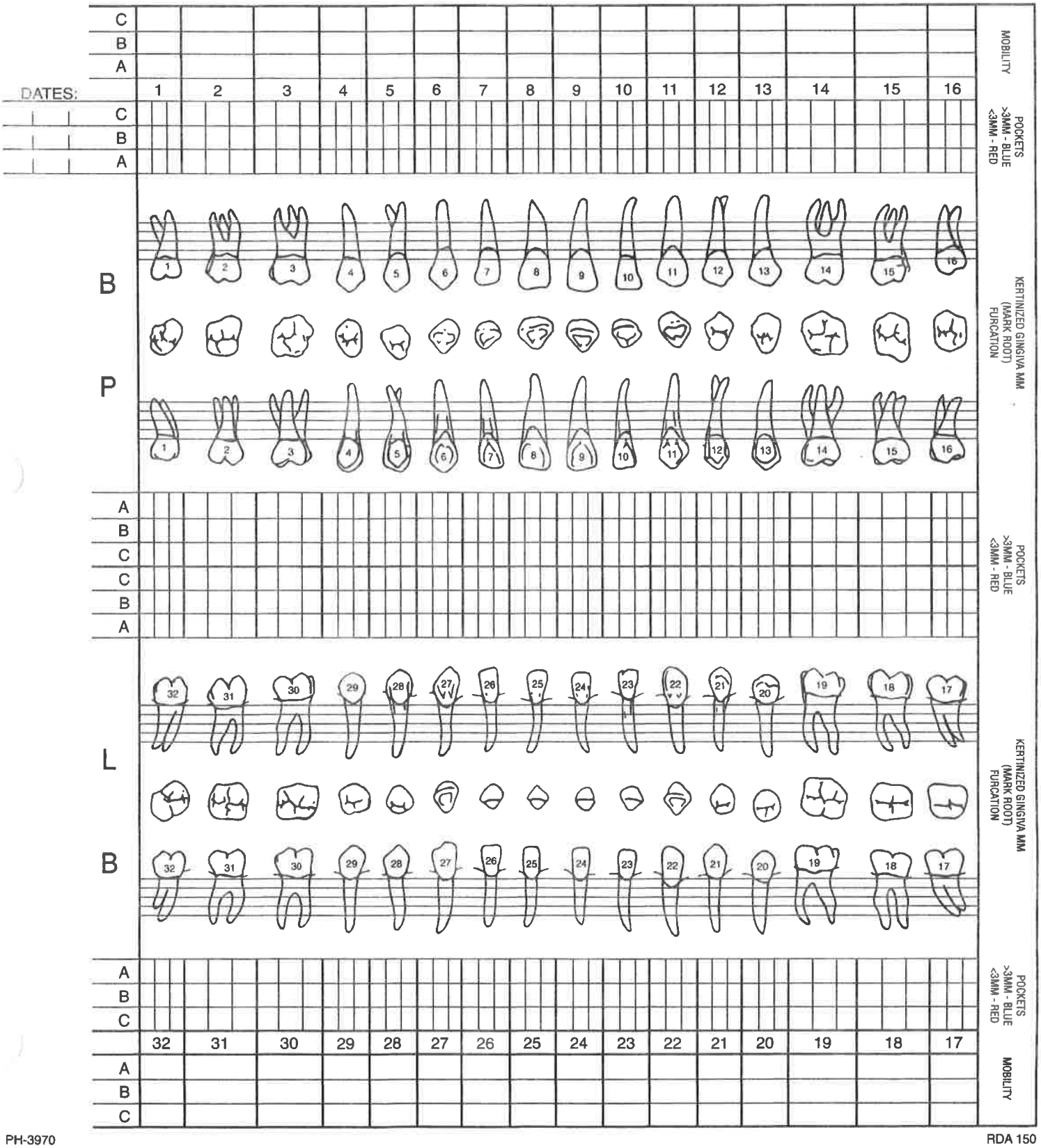
AFFIX LABEL

Tennessee Department of Health
Oral Health Services
Periodontal Charting Record

Med. Alert_____

Circle Box:
Bleeding in Red
Exudate in Blue



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AFFIX LABEL

Tennessee Department of Health
Oral Health Services
Periodontal Charting Record

Med. Alert_____

Circle Box:
Bleeding in Red
Exudate in Blue

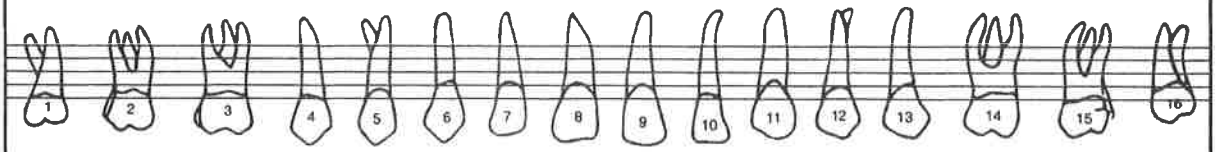
DATES:

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
C																
B																
A																

MOBILITY

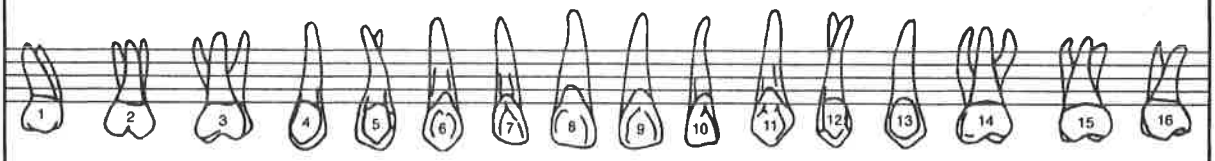
POCKETS >3MM - BLUE <3MM - RED

B



KERTINIZED GINGIVA MM (MARK ROOT) FURCATION

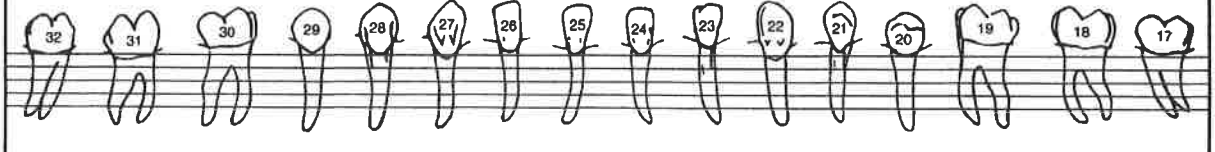
P



	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
A																
B																
C																
C																
B																
A																

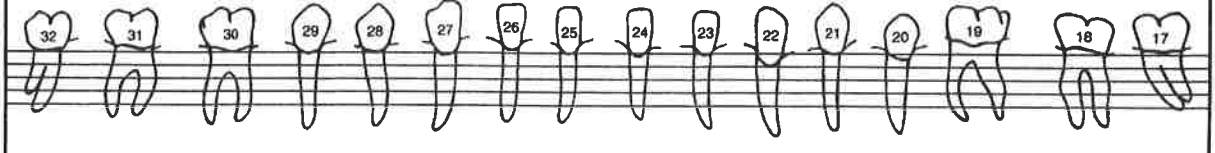
POCKETS >3MM - BLUE <3MM - RED

L



KERTINIZED GINGIVA MM (MARK ROOT) FURCATION

B



	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
A																
B																
C																

POCKETS >3MM - BLUE <3MM - RED

	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17
A																
B																
C																

MOBILITY

PH-3970

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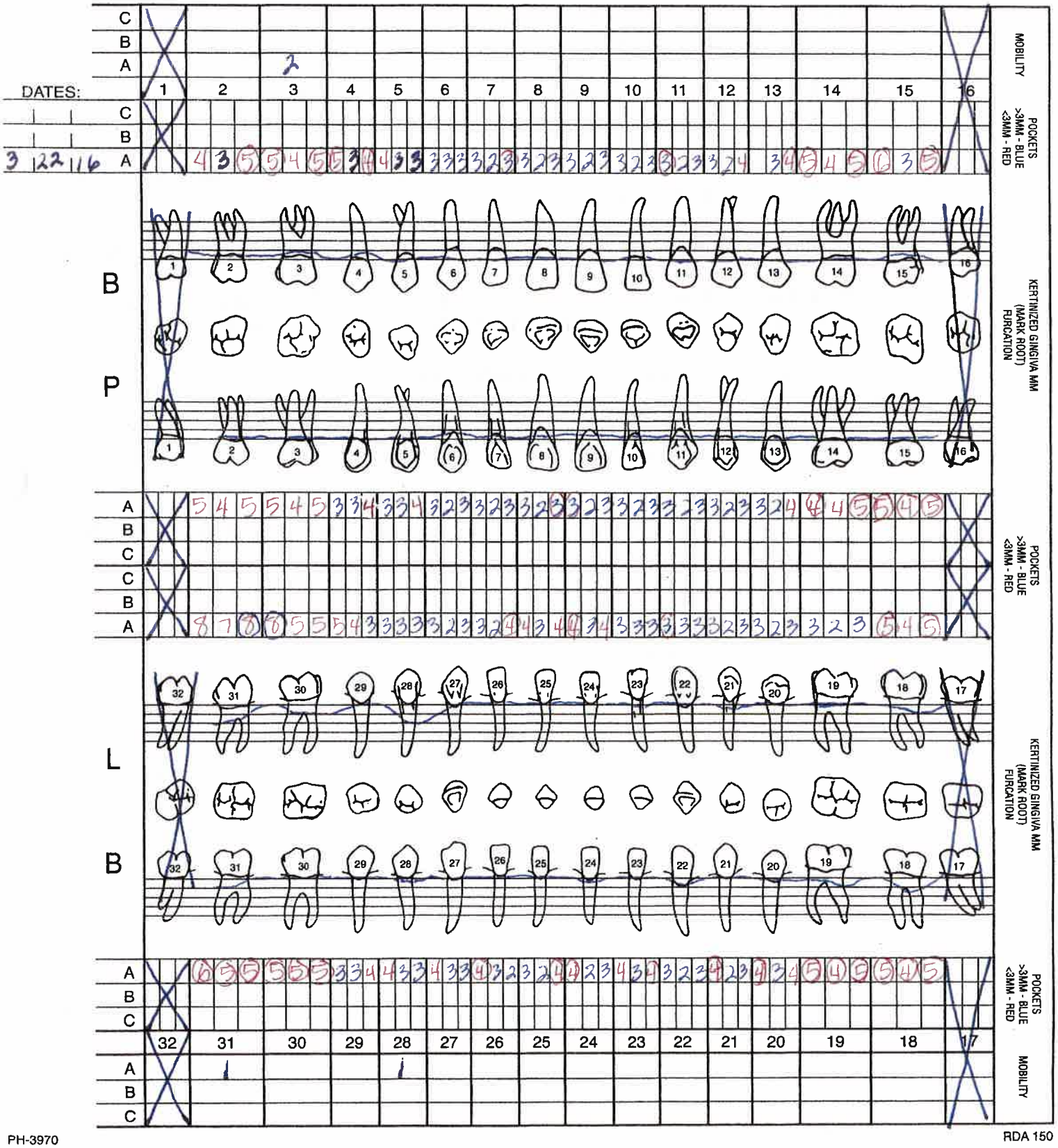
SAMPLE

AFFIX LABEL

Tennessee Department of Health
Oral Health Services
Periodontal Charting Record

Med. Alert_____

Circle Box:
Bleeding in Red
Exudate in Blue



PH-3970

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Periodontal Charting Record

Instructions and Examples for Periodontal Charting

1. Begin by checking for missing teeth and mobility. Missing teeth are recorded on the form by marking an X over the tooth diagram and an X over the corresponding probing box. (See example).

2. Mobility is recorded in the appropriate box that corresponds with the tooth number.
   a. Class 1 – Slight mobility, up to 1mm of horizontal displacement in a facial-lingual direction.
   b. Class 2 – Moderate mobility, greater than 1mm of horizontal displacement in a facial-lingual direction.
   c. Class 3 – Severe mobility, greater than 1mm of displacement in a facial-lingual direction combined with vertical displacement (tooth depressible in the socket).

3. Periodontal probing readings are recorded on the form. The pocket readings will be recorded in the boxes located above the tooth. Measurements should be recorded as follows:
   a. Numbers 1 – 3 should be written in blue pencil or ink
   b. Numbers 4 and above should be written in red pencil or ink
   c. Bleeding is indicated by circling the box in red – see example
   d. Suppuration (exudate) is indicated by circling the box in blue – see example

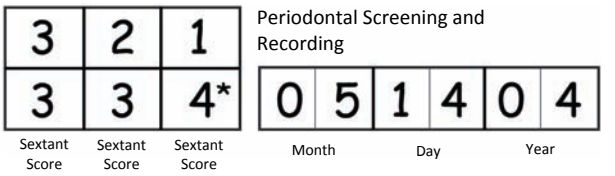
4. Gingival recession can be annotated by drawing a line corresponding to the recession on the lines on the tooth. Each line represents 2mm of recession. Recession can be drawn in blue pencil or ink. (See example)

   _____0mm – no recession
   _____ 2mm
   _____ 4 mm
   _____ 6 mm etc.

Implications of PSR Codes	
Code	**Further Clinical Documentation**
Code 0, 1, or 2 in all sextants	No further documentation needed
Code 3 in one sextant	Comprehensive periodontal assessment of sextant with 3 code
Code 3 in two or more sextants	Comprehensive periodontal assessment of entire mouth
Code 4 in one or more sextants	Comprehensive periodontal assessment of entire mouth

Documenting PSR Codes

For a PSR completed the PSR box chart would look like the chart shown below.



On this sample PSR chart, the following codes have been entered:

- Maxillary right posteriors = Code 3
- Maxillary anterior sextant = Code 2
- Maxillary left posteriors = Code 1
- Mandibular right posteriors = Code 3
- Mandibular anterior sextant = Code 3
- Mandibular left posteriors = Code 4 plus the * symbol to indicate one of the following problems: furcation involvement, mobility, mucogingival problems, or recession extending into the colored area of the probe.

Tennessee Department of Health
Oral Health Services

Dental Examination and Operative Record

DATE	TOOTH NUMBER	SERVICE RENDERED	SIGNATURE/TITLE (Full Name)

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Tennessee Department of Health
Oral Health Services

Dental Examination and Operative Record

DATE	TOOTH NUMBER	SERVICE RENDERED	SIGNATURE/TITLE (Full Name)

Tennessee Department of Health
Oral Health Services

INFORMED CONSENT FOR ORAL & MAXILLOFACIAL SURGERY

Patient Name: _____
First Middle Initial Last

Procedure: Extraction (Removal) of Tooth Number(s):_____

Alternatives to surgery: I understand that if this tooth/teeth are not removed my condition may worsen resulting in complications including but not limited to:

1. Infection
2. Loss of additional teeth
3. Pain

Possible complications which have been discussed with me include, but are not limited to:

1. Injury of the nerves of the lower lip and tongue causing numbness, which could possibly be permanent
2. Bleeding and/or bruising which may be prolonged
3. Dry socket
4. Involvement of the sinus above the upper teeth
5. Infection
6. Decision to leave a small piece of root in the jaw when its removal would require extensive surgery and increased risk of complications
7. Injury to adjacent teeth or fillings
8. Unusual reaction to medications given or prescribed
9. Referral to an Oral Surgeon for follow-up as needed

I have had the opportunity to discuss my surgery with Dr. _____ and to ask questions. I consent to surgery as described.

_____ _____
Patient, Parent or Guardian's Signature Date

_____ _____
Doctor's Signature Date Witness's Signature Date

Departamento de Salud de Tennessee
Servicios de Salud Orales

CONSENTIMIENTO INFORMADO PARA CIRUGÍA BUCAL Y MAXILOFACIAL

Nombre del paciente: _____
Nombre Inicial del segundo nombre Apellido

Procedimiento: Extracción de diente o dientes número: _____

Alternativas a la cirugía: Entiendo que si no se extrae este diente o estos dientes, el problema puede empeorar y dar lugar a complicaciones, entre otras:

1. Infección
2. Pérdida de otros dientes
3. Dolor

Se me explicaron las posibles complicaciones que incluyen, entre otras:

1. Lesión de los nervios del labio inferior y la lengua, la cual causa entumecimiento que podría ser permanente
2. Hemorragia y/o moretones que pueden prolongarse
3. Alvéolo seco
4. Afectación de los senos que se encuentran sobre los dientes superiores
5. Infección
6. La decisión de dejar un pedazo pequeño de raíz en la mandíbula cuando su extracción requeriría cirugía de consideración y mayor riesgo de complicaciones
7. Lesiones en los dientes o empastes vecinos
8. Reacción inusual a medicamentos administrados o recetados
9. Remisión a un cirujano bucal para atención de seguimiento según sea necesaria

Tuve oportunidad de hablar con el cirujano, Dr. _____, y de hacer preguntas. Doy mi consentimiento para realizar la cirugía según se describe.

_____ _____
Firma del paciente, padre, madre o tutor Fecha

_____ _____
Firma del médico Fecha Firma del testigo Fecha

Tennessee Department of Health
Oral Health Services

INFORMED CONSENT FOR ORAL SURGERY IN PATIENTS WHO HAVE RECEIVED ORAL BISPHOSPHONATE DRUGS

Patient Name: _____
First Middle Initial Last

Procedure: Extraction (Removal) of Tooth/Teeth _____

Please initial each paragraph after reading. If you have any questions, please ask the dentist BEFORE initialing.

____ 1. I have been treated with oral Bisphosphonate drugs and have been informed that my treatment with this drug places me at risk for severe complications occurring with dental treatment. Jaw bones usually heal themselves very well and maintain their normal health. In some patients, however, Bisphosphonate drugs have been documented to affect the ability of jaw bones to break down or remodel themselves, interfering with the jaw's ability to heal itself. This risk is increased after surgery, especially from extractions, gum surgery or other "invasive" procedures that might cause even mild trauma to bone. I understand that Necrosis (dying cells) or Osteonecrosis (dying bone cells) may result, and an infection may occur in the soft tissue and/or inside the bone. This is a long-term process that destroys the jawbone and is often very hard or impossible to clear up. If osteonecrosis should occur, treatment may be long and difficult. Osteonecrosis can result in ongoing intensive therapy that can include hospitalization, taking antibiotics for a long time, and removal of dead bone. Reconstructive surgery may be needed, including bone grafting, metal plates and screws, and/or skin flaps and grafts.

____ 2. I understand that my complete medical/dental history is **very** important and that I must inform staff of the medications and drugs I have received or taken before **and** am receiving or taking now. An accurate medical history, including names of physicians, is important. I understand the importance of supplying my health history and understand that failure to give accurate health information may be harmful to my care and could lead to unwanted complications.

____ 3. I understand that if a complication occurs, antibiotic therapy may be used to help control infection. For some patients, such therapy may cause allergic responses or have undesirable side effects such as stomach discomfort, diarrhea, etc.

____4. I understand that even if there are no immediate complications from the proposed dental treatment, the area is always subject to breakdown by itself at any time and infection due to the unstable condition of the bone; even the smallest trauma from a toothbrush, chewing hard food, or denture sores may set off a complication.

____ 5. I understand that staff may refer me to an Oral Surgeon for long-term follow up after my extraction to check my condition. I understand the importance of keeping all of my scheduled appointments and that regular and frequent dental check-ups with my dentist are important to try to prevent breakdown and/or complications in my oral health.

____ 6. I understand that although my dentist will take precautions to avoid complications, the absence of complications cannot be guaranteed.

____ 7. I have reviewed and signed the "Informed Consent for Oral & Maxillofacial Surgery."

CONSENT

I certify that I speak, read and write English, or have used a translator to explain all of the previous information to me, and that I understand all of the information above. I give my permission and consent to the procedure(s) proposed. All of my questions have been answered and all necessary information has been completed on this form prior to my initials or signature.

Patient/Parent/Guardian's Signature Date

Doctor's Signature Date

Witness' Signature Date

Departamento de Salud de Tennessee
Servicios de salud bucal

CONSENTIMIENTO INFORMADO PARA CIRUGÍA BUCAL EN PACIENTES QUE HAN RECIBIDO FÁRMACOS ORALES TIPO BIFOSFONATOS

Nombre del paciente: _____
Nombre Inicial del segundo nombre Apellido

Procedimiento: Extracción de diente o dientes: _____

Después de leer este consentimiento, escriba sus iniciales en cada párrafo. Si tiene alguna duda, pregunte al dentista ANTES de escribir sus iniciales.

____ 1. Recibí tratamiento con fármacos orales tipo bifosfonatos, y se me informó que el tratamiento con este fármaco representa para mí un riesgo de complicaciones graves al recibir tratamiento dental. Por lo general, los huesos de la mandíbula se consolidan muy bien por sí mismos y se mantienen normalmente sanos. No obstante, en algunos pacientes, existen datos acerca de que los fármacos bifosfonatos afectan la capacidad de los huesos de la mandíbula para desintegrarse o reestructurarse por sí mismos, lo cual interfiere con la capacidad de la mandíbula para consolidarse. El riesgo aumenta después de la cirugía, en especial, después de extracciones, cirugía de encía u otros procedimientos invasivos que pudieran causar incluso un traumatismo leve en el hueso. Entiendo que puede dar lugar a necrosis (muerte de células) u osteonecrosis (muerte de células óseas), y causar infección en el tejido blando o dentro del hueso, o en ambos. Es un proceso a largo plazo que destruye el hueso de la mandíbula y suele ser muy difícil o imposible de detener. Si se presenta la osteonecrosis, el tratamiento puede ser prolongado y difícil. La osteonecrosis puede dar lugar a un tratamiento intensivo continuo que puede incluir hospitalización, antibióticos por mucho tiempo y extracción del hueso muerto. Es posible que sea necesaria la cirugía reconstructiva, incluidos injertos de hueso, placas y tornillos metálicos, y/o colgajos e injertos de piel.

____ 2. Entiendo que mis antecedentes médicos y dentales completos son **muy** importantes, y que debo informar al personal de los medicamentos y fármacos que he recibido o tomado antes, **y** de los que estoy recibiendo o tomando actualmente. Es importante contar con antecedentes médicos precisos, que incluyan los nombres de los médicos. Entiendo la importancia de proporcionar mis antecedentes médicos, y que no dar información precisa sobre mi salud puede ser perjudicial para mi tratamiento y podría causar complicaciones inoportunas.

____ 3. Entiendo que si hay complicaciones, se puede aplicar tratamiento con antibióticos para controlar la infección. En algunos pacientes, dicho tratamiento puede causar reacciones alérgicas o tener efectos secundarios inconvenientes, como molestias estomacales, diarrea, etc.

____ 4. Entiendo que, incluso si no se presentan complicaciones inmediatas a causa del tratamiento dental propuesto, esa área siempre está sujeta a desintegrarse por sí misma en cualquier momento y a infectarse debido a las condiciones inestables del hueso. Hasta el más pequeño traumatismo causado por el cepillo de dientes, por masticar alimentos duros o por llagas debido a prótesis dentales puede dar lugar a complicaciones.

____ 5. Entiendo que, después de la extracción, el personal puede remitirme a un cirujano maxilofacial para recibir seguimiento a largo plazo y controlar esta afección. Entiendo la importancia de asistir a todas mis citas programadas, y que todas las revisiones dentales periódicas y frecuentes con el dentista son importantes para tratar de prevenir la desintegración y/o las complicaciones de mi salud bucal.

____ 6. Entiendo que, aunque el dentista tomará precauciones para evitar las complicaciones, no puede garantizarse que no habrá complicaciones.

____ 7. Leí y firmé el Consentimiento informado para cirugía bucal y maxilofacial.

CONSENTIMIENTO

Certifico que hablo, leo y escribo el inglés, o que recibí los servicios de un traductor para explicarme la información anterior, y que entiendo toda la información. Otorgo mi permiso y consentimiento para los procedimientos propuestos. Recibí respuesta a todas mis preguntas y se completó toda la información necesaria en este formulario antes de escribir mis iniciales y de firmarlo.

Firma del paciente, padre, madre o tutor _____ Fecha _____

Firma del médico _____ Fecha _____

Firma del testigo _____ Fecha _____

WHAT TO DO AFTER EXTRACTION OF A TOOTH

If a gauze pack has been placed on the extraction site, continue biting on it with steady pressure for 30 minutes. Do ***not*** chew on the gauze.

A little bleeding or oozing is normal after the gauze is removed. You will likely have a little blood mixed with your saliva for up to 36 hours; however, if heavy bleeding continues, call your dentist.

THE CLOT

After an extraction, the blood clot that forms in the socket is an important part of the healing process, and it can easily be disturbed. Here's how to protect it and help avoid a painful dry socket:

1. ***Do not smoke***. You are leaving here with an open wound. If you smoke before it heals, you slow the healing process and cause more pain for yourself.

2. Do not spit, rinse your mouth, or drink through a straw for 24 hours. Eat only soft foods. ***Do not*** drink carbonated beverages.

3. Do not try to clean the teeth next to the socket for the rest of the day. You should brush and floss your other teeth to reduce bacteria in your mouth.

SWELLING AND PAIN

You may have some swelling and discomfort after oral surgical procedures. A cold compress may help reduce swelling if begun within 30 minutes and apply gently on and off for 1 to 2 hours, but this is usually not necessary.

Small sharp bone fragments may come through the gums during healing. These are not roots. If this becomes a problem, call the health department dental clinic.

MEDICATION

If medication has been prescribed, use it exactly as directed. Do not increase the dosage. If you notice an upset stomach or other unusual reaction even though you followed instructions, stop the medication and call your dentist. For mild pain, use any non-aspirin type pain medication.

If you have prolonged or severe pain, swelling, bleeding, or fever call the health department at once.

DIET

Drink lots of liquids and eat soft, nutritious foods. Avoid alcoholic beverages and hot liquids. For at least two days, try to chew on the side opposite the surgery site.

RINSING AND ORAL HYGIENE

After 24 hours, begin gently rinsing with warm salt water (1/2 teaspoon of salt in 8 ounces of water). Avoid using any mouthwash containing alcohol during this early healing period.

Remember: The proper care following oral surgical procedures will speed up recovery and prevent complications.

Department of Health, Authorization No. 343731, No. of Copies 6,000
This public document was promulgated at a cost of $0.06 per copy.
11/10 DH-0064

ED# 1000050695

LOS PASOS A SEGUIR **DESPUÉS** DE UNA EXTRACCIÓN DE UN DIENTE

Si le pusieron una gasa en el lugar de la extracción, muérdala y mantenga la presión durante 30 minutos. No mastique la gasa.

Un poco de sangre o supuración es normal después que se quite la gasa. Lo más probable es que tenga un poco de sangre en la saliva hasta durante 36 horas; sin embargo, si tiene mucha hemorragia, llame al dentista.

EL COÁGULO

Después de una extracción, el coágulo de sangre que se forma en el hueco es una parte importante del proceso de cicatrización, y se puede afectar fácilmente. A continuación le explicamos cómo protegerlo y evitar una dolorosa alveoalgia:

1. No fume. Ud. sale de aquí con una herida abierta. Si fuma antes de que cicatrice, hará que se demore el proceso de cicatrización y tenga más dolor.

2. No escupa, ni se enjuague la boca, ni tome líquidos a través de una pajita durante 24 horas; ingiera alimentos blandos solamente. No tome bebidas con gas.

3. Trate de no limpiarse los dientes cerca del hueco en lo que queda del día. Debe cepillarse y usar el hilo dental en el resto de la dentadura para reducir las bacterias en la boca.

INFLAMAC ÓN Y DOLOR

Después de un procedimiento quirúrgico oral puede que tenga un poco de inflamación y dolor. Una compresa fría podría ayudar a reducir la inflamación si se la pone 30 minutos después del procedimiento y continúa poniéndosela y quitándosela durante 1 o 2 horas, pero por lo general esto no es necesario.

Durante el proceso de cicatrización, puede que le salgan pequeños fragmentos de hueso áspero de la encía. Estas no son las raíces, si se convirtiera en un problema, llame a la clínica dental del departamento de salud.

MED CAMENTOS

Si le recetaron algún medicamento, tómeselo tal y como se lo recetaron. No aumente la dosis. Si nota que le duele el estómago o alguna otra reacción poco común aunque haya cumplido las indicaciones, deje de tomar el medicamento y llame al dentista. Si tiene un poco de dolor, tome cualquier medicamento que sea para el dolor pero que no contenga aspirina.
Si el dolor continua o se intensifica, o si tiene mucha inflamación, o hemorragia o fiebre, llame al departamento de salud inmediatamente.

DIETA

Tome mucho líquido y coma comidas blandas y nutritivas. Evite las bebidas alcohólicas y los líquidos calientes. Durante dos días por lo menos, trate de masticar en el lado opuesto de la operación.

ENJUAGUE E HIGIENE BUCAL

Después que pasen 24 horas, comience a enjuagarse con cuidado con agua tibia con sal (1/2 cucharadita de sal en 8 onzas de agua). Evite usar todo enjuague de boca que contenga alcohol durante los primeros días del período de cicatrización.

Recuerde: Un buen cuidado después de un procedimiento quirúrgico oral le ayudará a una pronta recuperación y a prevenir complicaciones.

Tennessee Department of Health
Oral Health Services
Dental Encounter

PT. NO:
NAME:
DATE:
ENCOUNTER NO:

ADULT

VISIT SETTING 01 02 06
REIM:
PLAN:
NOTE:
DX CODE: Z01.20
DX CODE: Z01.21
DX CODE: K08.9

	DESCRIPTION	CODE	PROV	PRG	QTY	REST/REF	REST/REF	REST/REF
DIAGNOSTIC	Periodic Oral Evaluation	D0120		DN				
	Limited Oral Evaluation – Problem Focused	D0140		DN				
	Comprehensive Oral Evaluation	D0150		DN				
	Comprehensive Periodontal Evaluation	D0180		DN				
	Intraoral – Complete Series (Including Bitewings)	D0210		DN				
	Intraoral – Periapical First Radiographic Image	D0220		DN				
	Intraoral – Periapical Additional Radiographic Image	D0230		DN				
	Intraoral – Occlusal Radiographic Image	D0240		DN				
	Bitewing – Single Radiographic Image	D0270		DN				
	Bitewings – 2 Radiographic Images	D0272		DN				
	Bitewings – 4 Radiographic Images	D0274		DN				
	Panoramic Radiographic Image	D0330		DN				
PREV	Prophylaxis – Adult	D1110		DN				
	Fluoride Varnish	D1206		DN				
	Oral Hygiene Instructions	D1330		DN				
RESTORATIVE	Amalgam – 1 Surface	D2140		DN				
	Amalgam – 2 Surfaces	D2150		DN				
	Amalgam – 3 Surfaces	D2160		DN				
	Amalgam – 4 or More Surfaces	D2161		DN				
	Resin-Based Composite – 1 Surface, Anterior	D2330		DN				
	Resin-Based Composite – 2 Surfaces, Anterior	D2331		DN				
	Resin-Based Composite – 3 Surfaces, Anterior	D2332		DN				
	Resin-Based Composite – 4 or More Surfaces, Anterior	D2335		DN				
	Resin-Based Composite, 1 Surface, Posterior	D2391		DN				
	Resin-Based Composite, 2 Surfaces, Posterior	D2392		DN				
	Resin-Based Composite, Three Surfaces, Posterior	D2393		DN				
	Resin-Based Composite, Four or more Surfaces, Posterior	D2394		DN				
	Protective Restoration	D2940		DN				
	Core Buildup Including Pins	D2950		DN				
PROSTH	Crown – Porcelain, Predominately Base Metal	D2751		DN				
	Crown – Porcelain, Noble Metal	D2752		DN				
	Crown – Full Cast Predominately Base Metal	D2791		DN				
	Re-cement Crown	D2920		DN				
	Prefabricated Stainless Steel Crown – Permanent Tooth	D2931		DN				
OS	Extraction – Erupted or Exposed Primary or Permanent	D7140		DN				
	Surgical Extraction – Erupted Tooth or Exposed Root	D7210		DN				
ENDO	Therapeutic Pulpotomy	D3220		DN				
	Pulpal Debridement, Primary and Permanent Teeth	D3221		DN				
	Endodontic Therapy – Anterior	D3310		DN				
	Endodontic Therapy – Bicuspid	D3320		DN				
	Endodontic Therapy – Molar	D3330		DN				
MISC	Periodontal Scaling & Root Planing – Quadrant	D4341		DN				
	Full Mouth Debridement	D4355		DN				
	Periodontal Maintenance	D4910		DN				
	Alveoloplasty with Extractions – Four or More Teeth	D7310		DN				
	Alveoloplasty without Extractions	D7320		DN				
	Palliative Treatment	D9110		DN				
	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis	D9230		DN				
	Office Visit for Observation – No Other Services Provided	D9430		DN				
	Occlusal Guard	D9940		DN				
	Recheck	3734		DN				
	Smoking Cessation	99401QT		QT				
	TennCare Advocacy	99401T		TO				
	TennCare Advocacy	99402T		TO				
	Interpreter Codes	INT 1		DN		INT 2	INT 3	INT 4

Tennessee Department of Health
Oral Health Services
Dental Encounter

PT. NO:
NAME:
DATE:
ENCOUNTER NO:

CHILD

VISIT SETTING 01 02 06
REIM:
PLAN:
NOTE:
DX CODE: Z01.20
DX CODE: Z01.21
DX CODE: K08.9

	DESCRIPTION	CODE	PROV	PRG	QTY	REST/REF	REST/REF	REST/REF
DIAGNOSTIC	Periodic Oral Evaluation	D0120		DN				
	Limited Oral Evaluation – Problem Focused	D0140		DN				
	Oral Evaluation For Child Under 3 Years of Age	D0145		DN				
	Comprehensive Oral Evaluation	D0150		DN				
	Intraoral – Complete Series (Including Bitewings)	D0210		DN				
	Intraoral – Periapical First Radiographic Image	D0220		DN				
	Intraoral – Periapical Additional Radiographic Image	D0230		DN				
	Intraoral – Occlusal Radiographic Image	D0240		DN				
	Bitewing – Single Radiographic Image	D0270		DN				
	Bitewings – 2 Radiographic Images	D0272		DN				
	Bitewings – 4 Radiographic Images	D0274		DN				
	Panoramic Radiographic Image	D0330		DN				
PREVENTIVE	Prophylaxis – Child (0-12 Years)	D1120		DN				
	Prophylaxis – Child (13-20 Years)	D1110		DN				
	Fluoride Varnish	D1206		DN				
	Oral Hygiene Instructions	D1330		DN				
	Sealant	D1351		DN		02/0	03/0	04/0
	Sealant	D1351		DN		05/0	12/0	13/0
	Sealant	D1351		DN		14/0	15/0	18/0
	Sealant	D1351		DN		19/0	20/0	21/0
	Sealant	D1351		DN		28/0	29/0	30/0
	Sealant	D1351		DN		31/0		
	Preventive Resin Restoration	D1352		DN				
	Space Maintainer – Fixed, Unilateral	D1510		DN				
	Re-cement or Re-bond Space Maintainer	D1550		DN				
RESTORATIVE	Amalgam – 1 Surface	D2140		DN				
	Amalgam – 2 Surfaces	D2150		DN				
	Amalgam – 3 Surfaces	D2160		DN				
	Amalgam – 4 or More Surfaces	D2161		DN				
	Resin-Based Composite – 1 Surface, Anterior	D2330		DN				
	Resin-Based Composite – 2 Surfaces, Anterior	D2331		DN				
	Resin-Based Composite – 3 Surfaces, Anterior	D2332		DN				
	Resin-Based Composite – 4 or More Surfaces, Anterior	D2335		DN				
	Resin-Based Composite – One Surface, Posterior	D2391		DN				
	Resin-Based Composite – Two Surfaces, Posterior	D2392		DN				
	Resin-Based Composite – Three, Surfaces Posterior	D2393		DN				
	Resin-Based Composite – 4 or More Surfaces, Posterior	D2394		DN				
	Protective Restoration	D2940		DN				
	Core Buildup Including Pins	D2950		DN				
PROS	Re-cement Crown	D2920		DN				
	Prefabricated Stainless Steel Crown – Primary Tooth	D2930		DN				
	Prefabricated Stainless Steel Crown – Permanent Tooth	D2931		DN				
OS	Extraction – Erupted or Exposed Primary or Permanent	D7140		DN				
	Surgical Extraction – Erupted Tooth or Exposed Root	D7210		DN				
ENDO	Therapeutic Pulpotomy	D3220		DN				
	Pulpal Debridement, Primary and Permanent Teeth	D3221		DN				
	Endodontic Therapy – Anterior	D3310		DN				
	Endodontic Therapy – Bicuspid	D3320		DN				
	Endodontic Therapy – Molar	D3330		DN				
MISC	Periodontal Scaling & Root Planing – Quadrant	D4341		DN				
	Full Mouth Debridement	D4355		DN				
	Palliative Treatment	D9110		DN				
	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis	D9230		DN				
	Office Visit for Observation – No Other Services Provided	D9430		DN				
	Recheck	3734		DN				
	TennCare Advocacy	99401T		TO				
	TennCare Advocacy	99402T		TO				
	Interpreter Codes	INT 1		DN		INT 2	INT 3	INT 4

______________Clinic

Autoclave and Spore Test Log
2010

Type of Autoclave___________
Sterilizer Number___________

Run Date	Sterilization Load Label	Autoclave Not in Use	Date Attest & Time In Incubator/Initials	Date Attest & Time Out Incubator/Initials	Spore Test* (circle one) (-) is purple (+) is yellow		Date Autoclave Cleaning (every month, every 25-30 loads)	Initials	Comments
					Results	Control			
		☐			+ -	+ -			
		☐			+ -	+ -			
		☐			+ -	+ -			
		☐			+ -	+ -			
		☐			+ -	+ -			
		☐			+ -	+ -			
		☐			+ -	+ -			
		☐			+ -	+ -			
		☐			+ -	+ -			
		☐			+ -	+ -			
		☐			+ -	+ -			

*The autoclave indicator should be negative; the control indicator should be positive.

______________Clinic

Autoclave and Spore Test Log
2010

Type of Autoclave___________
Sterilizer Number___________

Run Date	Sterilization Load Label	Autoclave Not in Use	Date Attest & Time In Incubator/Initials	Date Attest & Time Out Incubator/Initials	Spore Test* (circle one) (-) is purple (+) is yellow Results	Control	Date Autoclave Cleaning (every month, every 25-30 loads)	Initials	Comments
		☐			+ -	+ -			
		☐			+ -	+ -			
		☐			+ -	+ -			
		☐			+ -	+ -			
		☐			+ -	+ -			
		☐			+ -	+ -			
		☐			+ -	+ -			
		☐			+ -	+ -			
		☐			+ -	+ -			
		☐			+ -	+ -			
		☐			+ -	+ -			

*The autoclave indicator should be negative; the control indicator should be positive.

Waterline Treatment and Monitoring Form

_____ Clinic Name & Number of Dental Unit _____

Treatment Date	Shock Treatment Date	Weekly Treatment (check one) Yes	No	Treatment Product Name	Water Lines Used For Testing	Waterline Monitoring Results <500cfu	>500cfu	Product Or Company Used and Date Results Returned	Signature

Clinical Competency Checklist for Dental Assistants 1

Name of Employee		Date of Hire	
Region		County	

Delegable Duties	Assistant's Signature	Dentist's Signature	Date of Completed Training
1). The maintenance of instrument and operatory infection control			
2.) The preparation of instrument trays			
3.) The processing of radiographs, including digital, of the mouth, gums, jaws, teeth or any portion thereof for dental diagnoses.			
4.) The taking and recording of a patient's blood pressure, pulse, temperature, and medical history and charting of oral conditions.			
5.) The application of topical anesthetics.			
6.) The placement and removal of rubber dam.			
7.) The placement and removal of matrices for restoration.			
8.) Placement of cavity bases and liners			
9.) Application of tooth conditioners for bonding.			
10.) The placement of amalgam in prepared cavities for condensation by the dentist.			
11.) Selecting and pre-fitting of stainless steel crowns or other pre-formed crowns for insertion by the dentist.			
12.) Removal of cement from restorations and bands.			
13.) Removal of cement excess from supragingival surface of teeth by hand instruments only.			
14.) Packing and removing retraction cord, with or without vasoactive chemicals, for restorative dental procedures.			
15.) The fabrication, placement and removal of temporary restorations.			
16.) The application of topical fluorides.			
17.) The application of desensitizing agents.			
18.) Demonstration of oral hygiene procedures and oral health care regimen.			
19.) The instruction of patients in dietary principles.			
20.) Irrigating extraction site.			
21.) Wound care as directed.			
22.) Calling in prescriptions to the pharmacist as instructed by the employer/dentist.			
23.) Performing pulp testing.			
24.) Packing of pulpotomy paste.			
25.) Drying canals with absorbent paper points.			

Clinical Competency Checklist for Dental Assistants 1

Delegable Duties	Assistant's Initials	Dentist's Initials	Date of Completed Training
26.) The taking of alginate impressions for any purpose other than restorations.			
27.) The placement and removal of socket dressings.			
28.) The placement and removal of periodontal dressings			
29.) The removal of sutures and staples.			
30) The taking of oral cytologic smears.			
31.) The taking of dental plaque smears.			
32.) Removal of loose or broken bands or brackets.			
33.) Placement of springs on wires.			
34.) Placement of hooks on brackets.			
35.) Placement of chain elastics on brackets.			
36.) Ligation of arch wires to brackets.			
37.) The selection, prefitting, cementation, curing, and removing of orthodontic bands or brackets.			
38.) Bending, selecting and pre-sizing arch wires and placing arch wires after final adjustment and approved by the dentist.			
39.) The removal of ligature and arch wires.			
40) Placement and removal of pre-treatment separators.			
41.) Fitting, adjusting and cementation of correctional appliances.			
42.) Placement of exposure chains and attachments.			

Clinical Competency Checklist for Dental Assistants 2

Name of Employee		Date of Hire	
Region		County	

Delegable Duties	Assistant's Signature	Dentist's Signature	Date of Completed Training
1). The maintenance of instrument and operatory infection control			
2.) The preparation of instrument trays			
3.) The processing of radiographs, including digital, of the mouth, gums, jaws, teeth or any portion thereof for dental diagnoses.			
4.) The taking and recording of a patient's blood pressure, pulse, temperature, and medical history and charting of oral conditions.			
5.) The application of topical anesthetics.			
6.) The placement and removal of rubber dam.			
7.) The placement and removal of matrices for restoration.			
8.) Placement of cavity bases and liners			
9.) Application of tooth conditioners for bonding.			
10.) The placement of amalgam in prepared cavities for condensation by the dentist.			
11.) Selecting and pre-fitting of stainless steel crowns or other pre-formed crowns for insertion by the dentist.			
12.) Removal of cement from restorations and bands.			
13.) Removal of cement excess from supragingival surface of teeth by hand instruments only.			
14.) Packing and removing retraction cord, with or without vasoactive chemicals, for restorative dental procedures.			
15.) The fabrication, placement and removal of temporary restorations.			
16.) The application of topical fluorides.			
17.) The application of desensitizing agents.			
18.) Demonstration of oral hygiene procedures and oral health care regimen.			
19.) The instruction of patients in dietary principles.			
20.) Irrigating extraction site.			
21.) Wound care as directed.			
22.) Calling in prescriptions to the pharmacist as instructed by the employer/dentist.			

Clinical Competency Checklist for Dental Assistants 2

Delegable Duties	Assistant's Initials	Dentist's Initials	Date of Completed Training
26.) The taking of alginate impressions for any purpose other than restorations.			
27.) The placement and removal of socket dressings.			
28.) The placement and removal of periodontal dressings			
29.) The removal of sutures and staples.			
30) The taking of oral cytologic smears.			
31.) The taking of dental plaque smears.			
32.) Removal of loose or broken bands or brackets.			
33.) Placement of springs on wires.			
34.) Placement of hooks on brackets.			
35.) Placement of chain elastics on brackets.			
36.) Ligation of arch wires to brackets.			
37.) The selection, prefitting, cementation, curing, and removing of orthodontic bands or brackets.			
38.) Bending, selecting and pre-sizing arch wires and placing arch wires after final adjustment and approved by the dentist.			
39.) The removal of ligature and arch wires.			
40) Placement and removal of pre-treatment separators.			
41.) Fitting, adjusting and cementation of correctional appliances.			
42.) Placement of exposure chains and attachments.			

TENNESSEE DEPARTMENT OF HEALTH
COMMUNITY HEALTH SERVICES
QUALITY IMPROVEMENT PLAN
COUNTY IMPROVEMENT PLAN
2 Day Report

Date of Review: **Date of Response:**

Region: **Site:**

Review completed by:

Please list the Review Standard, the deficiency according to the review, and the immediate Plan of Action/Correction taken. Please indicate any patient/employee impact caused by the deficiency and/or steps being taken to identify the patients impacted.

Corrective Action to be taken: **(Please establish measurable goals)**

Person(s) Responsible for Improvement Plan development and implementation: (List name, title and date of approval)

1.

2.

3.

This plan should be written in consultation with and copied to the Regional Director and Regional Dental director, along with regional and state programs that are affected.

The completed report is to be emailed to Regional and State QI Directors, Regional Director, Regional Dental Directors and State Dental Director; to include when appropriate the State Pharmacy Director.

TENNESSEE DEPARTMENT OF HEALTH
COMMUNITY HEALTH SERVICES
QUALITY IMPROVEMENT
COUNTY/REGIONAL IMPROVEMENT PLAN

County Name: **Site Number:**

Region Name/Number:

Review Date: **Exit Conference Date:**

Reviewer(s):

Reviews: Prioritize: (Please list any of the following below: Standard(s) determined to be less than 90% met; any item(s) which have a major impact upon patients; any item(s) with legal aspect or any other issues the county/regional office would like to address.) Please list below Review, standard(s) of concern, percentage met, and how standards were not met.

Corrective action to be taken:

Person(s) Responsible for Improvement Plan development and implementation: (List name, title and date of approval)

1.

2.

3.

TENNESSEE
DEPARTMENT OF HEALTH
BOARD OF PHARMACY
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
615-741-2718

A REPORT TO A LOCAL LAW ENFORCEMENT AGENCY BY A PROVIDER OF A PERSON ATTEMPTING TO OBTAIN CONTROLLED SUBSTANCES BY DECEPTION

To:
Insert the appropriate local law enforcement agency (as indicated on the CSMD website):

_____

From:
Practitioner's name:_____

Office address:_____

_____

Phone number:_____

Date*:
_____ (***Date must be within five business days of the incident.***)

The above-named physician, dentist, optometrist, podiatrist, veterinarian, advanced practice nurse with a certificate of fitness issued under title 63, chapter 7, or physician assistant has actual knowledge that on _____ *(insert date)*, the following person;

Patient's Name: _____

Patient's Address: _____

_____

Driver's License Number & State: _____

Patient's DOB: _____

knowingly, willfully and with intent to deceive, obtained or attempted to obtain controlled substances by deceit or failing to disclose that he or she has received the same controlled substance or one of similar therapeutic use, **OR** a prescription for the same controlled substance or one of similar therapeutic use, from another practitioner within the previous 30 days.

SECTION 3

QUALITY IMPROVEMENT & QUALITY ASSURANCE REVIEW INSTRUMENT

TENNESSEE DEPARTMENT OF HEALTH
COMMUNITY HEALTH SERVICES
ORAL HEALTH SERVICES SECTION

QUALITY IMPROVEMENT REVIEW INSTRUMENT, QUALITY ASSURANCE REVIEW INSTRUMENT, & GUIDELINES AND CRITERIA FOR STANDARDS OF ACCEPTABLE QUALITY PUBLIC HEALTH DENTISTRY

Following are hyperlinks referring to Quality Improvement Information:

Peer Review: CHS 3.1.b – Professional Supervision

Quality Improvement Manual, 23rd Edition August 2015: Quality Improvement Manual

QUALITY ASSURANCE INSTRUMENT
DENTAL RECORD REVIEW
Tennessee Department of Health
Community Health Services – Oral Health Services Section

PATIENT'S CHART NUMBER

CRITERIA										
I.A. MEDICAL/DENTAL HISTORY										
Patient/Health History (A.1)										
Conditions Flagged (A.2)										
Signet and Dated /Consent for Treatment (A.3)										
History Updated (A.4)										
I.B. PATIENT EXAMINATION										
Blood Pressure (B.1)										
Oral Conditions (B.2)										
Caries Risk Assessment (B.3)										
I.C. RADIOGRAPHS										
Diagnostic Quality (C.1)										
BW/PA criteria (C.2)										
Pre-op Radiograph (C.3)										
I.D. TREATMENT										
Appropriate (D.1)										
Documentation of Informed Consent for Oral Surgery (D.2)										
I.E. PROGRESS NOTES										
Legible, Dated, and Signed (E.1)										
Progress Note (E.2)										
Charting of Treatment (E.3)										
Broken Appointments (E.4)										
Documentation of Referrals (E.5)										
Recall Plan (E.6)										
Corrections (E.7)										
I.F. OUTCOME MEASURES										
Appropriate Sealants Placed (F.1)										
Appropriate Fluoride Varnish Placed (F.2)										

Y - Yes N - No N/A – Not Applicable I – Insufficient information to determine

QUALITY ASSURANCE INSTRUMENT
DENTAL RECORD REVIEW

Dentist _____

Clinic Site _____ Reviewer _____

COMMENTS:

RECOMMENDATIONS:

I certify that the Findings of the Quality Assurance Dental Record Review have been explained to me and I understand the recommendations.

SIGNATURE OF DENTIST **DATE OF SIGNATURE**

SIGNATURE OF REVIEWER **DATE OF SIGNATURE**

GUIDELINES AND CRITERIA FOR STANDARDS OF ACCEPTABLE QUALITY PUBLIC HEALTH DENTISTRY

I. DENTAL RECORD REVIEW (20 Records must be reviewed)

A. MEDICAL/DENTAL HISTORY AND CONSENT

1. Key patient information (address, phone number, emergency information, and source of payment is on the appropriate form or the electronic record. The health questionnaire (medical history) contains **no** unanswered questions. Questions that are answered yes, must be explained, i.e. Are you seeing a Physician – Yes – Why.
2. Medical conditions or medications requiring an alert are flagged. Alerts are to be flagged using appropriate stickers for Med Alerts and Allergies or by using a Red Pen. Stickers or red annotations are to be placed on the Health History for Dental Services, and on the Clinic Oral Health & Treatment Record or in the appropriate location in the electronic record.
3. The medical history and consent for treatment are signed and dated by the patient or parent/guardian and the dentist. The patient's name must be written in the treatment consent line.
4. The medical history is updated at each appointment, and any change is noted on the appropriate form, in the electronic record or in the progress note. A new Health History must be completed annually.

B. PATIENT EXAMINATION

1. Blood pressure recordings are taken at the initial visit of adult patients and prior to all surgical, invasive or stressful procedures. Blood pressures are taken at each visit on patients with a history of hypertension.
2. Oral conditions including restorations, caries, periodontal status, oral hygiene status and any other pertinent observations are recorded on the appropriate forms or in the electronic record using standardized charting for each patient undergoing comprehensive or preventive care.
3. Caries Risk Assessment is an essential element for clinical care; each patients undergoing comprehensive or preventive care should have a documented caries risk assessment

C. RADIOGRAPHS

1. Radiographs have proper density, contrast, and detail.
2. Periapical radiographs include all of the crown, roots, and surrounding bone in the area of observation and are not distorted or overlapped (where anatomically possible). Bitewing radiographs split the contacts if possible and include the distal of the cuspids and the mesial of the last tooth in the arch. Bitewings are taken all initial exam appointments when there are close posterior contacts and updated based upon carious

activity, caries risk, disease activity or specific problems. Recall radiographs are taken at appropriate intervals.

3. A radiograph of diagnostic quality is taken prior to extracting any tooth (except primary teeth near exfoliation). Anterior periapicals or panorex radiograph must be taken prior to any restorative procedures performed on anterior teeth.

D. TREATMENT

1. The treatment for each patient is based on the history, examination, and diagnosis. The treatment follows a logical sequence. Normally, with minor variations, this is:

    a. Relief of pain and discomfort
    b. Elimination of infection and traumatic conditions
    c. Caries control (removal of soft, deep caries)
    d. Prophylaxis, preventive procedures, and oral hygiene instruction
    e. Endodontic therapy
    f. Periodontal therapy
    g. Necessary extractions
    h. Restoration of teeth
    i. Replacement of teeth
    j. Placement of the patient on an individualized recall schedule

2. *Informed Consent for Oral & Maxillofacial Surgery* (PH-3432) or Informed Consent for Patients Taking Oral Bisphosphonates (PH-4035) is completed for all oral surgery procedures. If the patient has taken an Oral Bisphosphonate drug, both forms must be filled out. If the patient has no previous history of taking Oral Bisphosphonates just the Informed Consent for Oral & Maxillofacial Surgery (PH-3432) needs to be completed.

E. PROGRESS NOTES

1. All progress notes are legible, dated, and signed by the provider on the date of service in blue or black ink, using signature found on Legal Signature Page, of dentist, hygienist or assistant and credentials (DDS).
2. Documentation of services (treatment) rendered contains the following at a minimum: (see example below)
    a. Date of service
    b. Tooth number, if appropriate, in tooth number block
    c. Description of the service
    d. Anesthetic used, if any - including quantity
    e. Materials used, if any – i.e. shade of comp, brand of amalgam, type of base etc.
    f. Prescriptions or medications dispensed including name of drug, quantity, and dosage- Documentation of CSMD check placed in the progress note prior to any narcotics being prescribed.
    g. Additional comments on referrals, consultations, and instructions
3. Standardized charting of treatment is completed in the appropriate tooth grids.
4. Broken appointments are documented in the progress note when possible.
5. Documentation of referral is kept in the patient’s chart.

6. A recall plan or next visit is included in the progress notes.
7. Errors should never be corrected with white out. A line should be drawn through the mistake to avoid the impression that a record may have been altered. CID (Correction in Documentation) is written immediately above the mistake, along with initials and date (if different from date of original entry).

Example of Progress Note:

1/18/07 **Pt. presents for operative #S (DO) & # T (M)**
Health History reviewed. NKDA. Pt. taking no meds. OHI reviewed.
Caries # S (DO), #T (M).
Tx plan:
1. Today: amalgam #S (DO), #T (M), Used ½ carp 2% Lido with epi 1:100,000. Removed all caries. #T – acid etched, 34% Caulk, bonded with Prime and bond NT, placed flowable composite, (Vivadent) shade A2. # S – placed amalgam (Tytin) checked margins and occlusion.
2. Findings & treatment explained to pt. Pt. dismissed in stable status.
3. Appt. made for #L (pulp & SSC).

John Doe, DDS

F. OUTCOME MEASURES

1. All pediatric patients should receive the appropriate sealants. Outcome measure should be at 90% or greater compliance; documented by the record review
2. All pediatric patients should receive appropriate fluoride varnish at initial visit. Outcome measure should be at 90% or greater compliance; documented by the record review

QUALITY ASSURANCE INSTRUMENT FOR THE
DIRECT OBSERVATION OF PATIENT CARE
Tennessee Department of Health
Community Health Services – Oral Health Services Section

PATIENT'S CHART NUMBER

CRITERIA										
II.A. INFECTION CONTROL										
Handwashing (A.1.)										
Personal Protective Equipment (A.2)										
Dental Unit Waterlines (A.3)										
Critical and Semi-critical Instruments (A.4)										
Disposables (A.5)										
II.B DIAGNOSIS										
Initial Exam/Recall Exam (B.1)										
Radiographs (B.2)										
Radiograph Techniques (B.3)										
Appropriate Diagnosis (B.4)										
II.C. PREVENTION										
Appropriate Preventive Procedures (C.1)										
Prophylaxis/Recall (C.2)										
Fluoride (C.3)										
Fluoride/Sealants (C.4)										
II.D. OPERATIVE DENTISTRY										
Work Practice Controls/Water Cooling Spray (D.1.)										
Restorations Reproduce Sound Tooth Contours/Appropriate Bases (D.2)										
Stainless Steel Crowns (D.3)										
Agitator Covered/Amalgam Scrap Recycled (D.4)										
II.E. PROSTHODONTICS										
Partial Dentures (E.1)										
Complete Dentures (E.2)										
Fixed (E.3)										

Y - Yes N - No N/A – Not Applicable I – Insufficient information to determine

PATIENT'S CHART NUMBER

CRITERIA										
II.F. ENDODONTICS										
Radiograph (F.1.)										
Rubber Dam (F.2.)										
Obturation of Canal (F.3.)										
Pulpotomies Performed (F.4.)										
II.G. PERIODONTICS										
Proper Diagnosis (G.1.)										
Home Care Instructions (G.2.)										
Treatment (G.3.)										
Referrals (G.4)										
Recall (G.5.)										
II.H. ORAL SURGERY										
Complete Tooth Removal/Root Tip (H.1.)										
Pre-op Radiograph (H.2.)										
Written Informed Surgical Consent (H.3.)										
Post-op Instructions (H.4.)										
II.I. EMERGENCY TREATMENT										
Palliative Measures Taken/Efficacious Treatment (I.1.)										
Appropriate Diagnosis (I.2.)										
Appropriate Medications (I.3.)										
Appropriate Referrals (I.4.)										

Y - Yes N - No N/A – Not Applicable I – Insufficient information to determine

QUALITY ASSURANCE INSTRUMENT
DIRECT OBSERVATION OF PATIENT CARE

Dentist _____

Clinic Site _____ Reviewer _____

COMMENTS:

RECOMMENDATIONS:

I certify that the Findings of the Quality Assurance Direct Observation of Patient Care have been explained to me and I understand the recommendations.

SIGNATURE OF DENTIST **DATE OF SIGNATURE**

SIGNATURE OF REVIEWER **DATE OF SIGNATURE**

GUIDELINES AND CRITERIA FOR STANDARDS OF ACCEPTABLE QUALITY PUBLIC HEALTH DENTISTRY

II. QUALITY OF PATIENT CARE SERVICES

Direct Observation of Patient Care QA review must be conducted within the first 8 weeks of hire for new providers. Dental Providers are to have QA review at least every two years.

A. INFECTION CONTROL

1. Hands are washed thoroughly before and after treatment of each patient with antimicrobial soap or hand sanitizer.
2. Protective attire (gloves, masks, and eye, face, and long-sleeved gowns) is worn by all dental staff.
3. Dental unit waterlines to all instruments (high-speed handpiece, air/water syringe, and ultrasonic scaler) are flushed for several minutes at the beginning of the each clinic day and for a minimum of 20-30 seconds after use on each patient. Dental unit waterlines must be treated with appropriate products, and all water monitoring recommendations must be adhered to.
4. After thorough cleaning, all heat-stable instruments, including handpieces, are heat sterilized. Handpieces, to include low speed attachments & motors must be sterilized between patients.
5. Disposable covers and disposable supplies are used whenever possible. Disposable items are never reused.

B. DIAGNOSIS

1. An initial or recall examination is conducted on all patients receiving comprehensive and preventive care
    a. A caries risk assessment should be completed at the time of the initial or recall examination
2. Radiographs
    a. Initial radiographs for an adult patient consist of individualized films including bitewings with panoramic exam or bitewings and selected periapicals. A full-mouth intraoral radiographic examination is appropriate when the patient presents with clinical evidence of generalized dental disease or extensive dental treatment.
    b. For children with primary teeth only, radiographs are taken if proximal surfaces of the primary teeth cannot be visualized or if there are specific problems.
    c. For children with a transitional dentition, or an adolescent with permanent dentition, initial radiographs should consist of appropriate posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.
    d. Recall radiographs (bitewings) are taken at a frequency based on caries activity, caries risk, disease activity, or specific problems but should be taken at least once annually or more frequently if needed.

e. Recall radiographs (panoramic) for children with transitional dentition should be based on clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth & development. For adolescents with permanent dentition the recommendation is based on clinical judgment as to need for and type of radiographic images for evaluation and/or monitoring of dentofacial growth & development.

3. Radiograph Techniques
   a. Appropriate shielding to include thyroid collar is used on all patients receiving radiographs.
   b. Film positioners are used. Neither patient nor staff holds the film during exposure.
   c. Staff is protected from scattered radiation during film exposure.

4. Appropriate Diagnosis
   a. A proper diagnosis consists of the patient's state of oral health and the existence of any pathology or abnormal condition including the causes and type of the pathology or abnormal condition. The primary tools are the history and clinical examination.
   b. Patients with periodontal disease are informed of their periodontal condition(s), and appropriate referrals are made for consultation and treatment. All adult patients undergoing comprehensive care will have PSR completed and documented in progress note.

C. PREVENTION

1. Treatment includes appropriate preventive procedures for each patient undergoing comprehensive care, along with oral hygiene instructions.
2. Professional prophylaxis, which removes plaque, extrinsic stains, and calculus, is performed at regular intervals appropriate to the individual.
3. Fluoride varnish should be applied to prevent caries at the initial visit, as appropriate
4. Sealants are placed as a barrier to prevent caries, as appropriate

D. OPERATIVE DENTISTRY

1. Work practice controls are utilized to reduce formation of aerosols, droplets, and spatter. A water-cooling spray must be used with high-speed tooth reduction.
2. All restorations reproduce sound tooth contours, restore or achieve interproximal contact, and have flush margins. Bases are used appropriately.
3. Significant interproximal carious lesions on primary teeth are restored with stainless steel crowns.
4. The agitator of the amalgamator functions under a protective cover. Amalgam scrap is stored in a tightly closed container and recycled properly, to include extracted teeth with amalgam in them.

E. PROSTHODONTICS

1. **Partial Dentures**
   Clinically Acceptable

2. **Complete Dentures**
   Clinically Acceptable

3. **Fixed**
   Clinically Acceptable

F. ENDODONTICS

1. An accurate periapical radiograph of the involved tooth (including apices) is taken prior to the start of endodontic therapy.
2. A rubber dam must be used for all endodontic cases.
3. The root canal filling is densely packed and sealed to about one millimeter of the apex.
4. Pulpotomies are not performed on primary teeth with apical involvement, intraradicular involvement, or noticeable mobility.

G. PERIODONTICS

1. Periodontal treatment is preceded by examination to include periodontal charting, diagnosis, and treatment planning.
2. All patients are instructed in home care to attain plaque control and caries prevention.
3. Mild periodontal disease is treated by scaling, root planing, and replacing or modifying defective restorations.
4. Patients with moderate or advanced periodontal disease are referred to appropriate specialists for consultation, treatment, and follow-up care.
5. Periodontal patients treated in the clinic are placed on regular recall at intervals specific to the each patient.

H. ORAL SURGERY

1. When teeth are extracted, all portions of the tooth are removed, except under circumstances where injury to the surrounding hard and/or soft tissues is likely to occur with further attempts at retrieval. If it is necessary to leave a root tip, the patient is informed; treatment options including referral are discussed; and all pertinent information is documented in the patient's record.
2. A radiograph of diagnostic quality is taken prior to extracting any tooth (except primary teeth near exfoliation).
3. Written informed consent using form PH-3432. If the patient has taken an Oral Bisphosphonate drug, then the *Informed Consent for Patients Taking Oral Bisphosphonates* (PH-4035) must be completed as well. If the patient has no previous history of taking Oral Bisphosphonates only the Informed Consent for Oral & Maxillofacial Surgery (PH-3432) needs to be completed.

4. After extractions all patients are given oral & written post-operative instructions.

I. EMERGENCY TREATMENT

1. No patient is sent home or referred without measures taken to relieve his/her distress. The emergency condition is treated by the most efficacious method.
2. A sufficient number of radiographs of diagnostic quality are made, and other diagnostic aids are utilized, as needed, to reach a definitive diagnosis.
3. Appropriate antibiotics and/or analgesics are dispensed or prescribed as necessary. CSMD is checked prior to prescribing narcotics and required documentation is placed in the patient record.
4. Appropriate referrals are made and documented in the patient record.

SECTION 4

PROTOCOL FOR MANAGEMENT OF MEDICAL EMERGENCIES

TENNESSEE DEPARTMENT OF HEALTH
COMMUNITY HEALTH SERVICES
ORAL HEALTH SERVICES SECTION

PROTOCOL FOR MANAGEMENT OF MEDICAL EMERGENCIES

EMERGENCY MANAGEMENT of Medical Emergencies may be accessed in the Public Health Nurse Protocol Manual located in the local Health Department or it may be accessed on the Intranet, PHN, Section I: EMERGENCY MANAGEMENT

Emergency Telephone Number, Supplies, and Equipment

All Dental Health Care Workers (DHCWs) must be prepared to respond to patient-centered emergencies. CHS Policy 3.4.a. applies to all staff providing and/or supporting clinical services in public health regardless of the service delivery setting (i.e., local health department, regional office, school, or community site). All staff members must maintain an acceptable level of preparedness in order to respond competently when emergency action is required. All licensed staff must maintain current certification in an approved CPR course. Other staff, including clerical, must receive instruction in CPR.

The attached clinical procedures and medical protocol outline the steps to be followed in the event of a medical emergency in the dental clinic. This protocol will be reviewed at least annually or more often as indicated. In addition, each health department should conduct an unannounced patient emergency drill at least annually with a check sheet used for evaluation locally.

Emergency supplies and equipment must be kept in an accessible, easily identifiable location in the clinical setting (i.e., health department). The emergency kit and oxygen equipment must be at the site of the emergency within one minute. As outlined in CHS Policy 3.4.a – Patient – Centered Emergencies.

In the event of a patient-centered emergency, the dentist will remain with the patient and get an initial check of respiration and pulse. The dental assistant will activate 911 and get oxygen, the emergency kit, the emergency guidelines, blood pressure cuff, and stethoscope. The assistant will record what happens, the type and quantity of drugs given, vital signs, and the times that drugs are given and vitals are taken. If a physician is present in the facility, he/she should be paged. **The dental team will activate the Emergency alert as outlined in 8.4a.**

In an emergency, do not hesitate to call 911 or activate EMS!

Emergency telephone numbers:

Emergency Medical Services (EMS): **911**

Hospital Emergency Room: _____

Poison Control Center: **1-800-222-1222**

SECTION 5

INFECTION CONTROL POLICIES AND PROCEDURES

TENNESSEE DEPARTMENT OF HEALTH
COMMUNITY HEALTH SERVICES
ORAL HEALTH SERVICES SECTION

INFECTION CONTROL POLICIES AND PROCEDURES

For Infection Control Policies and Procedures for the Tennessee Department of Health, access the manual: TDH - Infection Control Manual - 2015

I. SCREENING AND REFERRAL PROGRAMS

Any dental screening and referral program or oral health survey designed for children or adults has need for adequate infection control protocols to assure that no cross-contamination occurs between the dental staff and the population being screened. Public health dentistry maintains a higher profile (i.e., a more visible role) in the community than the private sector because of school-based disease prevention programs and oral health promotion programs. Therefore, dental public health professionals should serve as role models in practicing and promoting sound infection control practices. At a minimum, these infection control protocols will include the following:

A. Precautions:

1. Place used tongue blades in a trash bag and dispose of them properly. Place used mouth mirrors in an appropriate container with disinfecting solution until such time that the mirrors can be cleaned, bagged, and sterilized.
2. It is recommended that charting of records be done by another person. If this is not possible, you must ensure that all Infection Control Protocols are followed to prevent any cross-contamination.

B. Proper Handling of Waste

It is not practical or necessary to treat items that have had contact with saliva as infectious from the standpoint of requiring special waste disposal precautions. (MMWR, Dec 19, 2003, Vol. 52, No. RR-17). Solid waste materials contaminated with saliva should be disposed of in the same manner as with other solid wastes.

II. DENTAL SEALANT PROGRAMS IN A PORTABLE DENTAL CARE ENVIRONMENT

Please see the *School Based Dental Prevention Program Manual* for recommendations concerning use of portable equipment.

III. PUBLIC HEALTH DENTAL CLINICS

Dental personnel in public health in Tennessee ***must*** comply with OSHA's Bloodborne Pathogens Standard.

Please click *here* to view the CDC's Guidelines for Infection Control in Dental Health-Care Settings – 2003, December 19, 2003 MMWR. These guidelines mandate the infection control protocol policies for the Department of Oral Health Services.

SECTION 6

ADDITIONAL RECOMMENDATIONS AND GUIDELINES

TENNESSEE DEPARTMENT OF HEALTH
COMMUNITY HEALTH SERVICES
ORAL HEALTH SERVICES SECTION

I. PREVENTION OF INFECTIVE ENDOCARDITIS (IE)

Current American Heart Association (AHA) recommendations for the prevention of Infective Endocarditis must be used when determining the need for prophylactic coverage during dental procedures.

American Heart Association (AHA) information is available at AHA - Infective Endocarditis

II. ANTIBIOTIC PROPHYLAXIS FOR DENTAL PATIENTS WITH TOTAL JOINT REPLACEMENT

Current recommendations from the American Academy of Orthopedic Surgeons (AAOS) must be followed when determining the need for antibiotic prophylaxis for dental patients with total joint replacement.

For an Information Statement from the AAOS regarding Antibiotic Prophylaxis for Patients after Total Joint Replacement.

AAOS and the ADA Release clinical practice guidelines on "The Prevention of Orthopaedic Implant Infections in Patients Undergoing Dental Procedures", December 7, 2012, AAOS - ADA Clinical Guidelines

III. TUBERCULOSIS INFECTION CONTROL RECOMMENDATION - CONSIDERATIONS FOR DENTISTRY

Tuberculosis (TB) is a respiratory disease caused by the bacteria *Mycobacterium tuberculosis.* The disease is spread when a susceptible individual inhales airborne particles (droplet nuclei containing TB bacilli) produced when an infected individual coughs, sneezes, laughs, or sings. For further information, dental public health staff should refer to the CDC published *Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Settings, 2005* (MMWR 2005;54,(RR-17);1-141).

CHS Policy 3.2.c. describes the policies regarding testing and risk determination of all employees, including part-time, contractual, and volunteers who have patient contact and are at risk of effective exposure.

IV. NITROUS OXIDE OCCUPATIONAL SAFETY

In an effort to reduce occupational health hazards associated with nitrous oxide, the American Academy of Pediatric Dentistry (AAPD) recommends exposure to ambient nitrous oxide be minimized through use of effective scavenging systems and periodic evaluation and maintenance of the delivery and scavenging systems.

POTENTIAL BENEFITS

- Reduction or elimination of anxiety
- Reduction of untoward movement and reaction to dental treatment

- Enhancement of communication and patient cooperation
- Raising of the pain reaction threshold
- Increasing the tolerance for longer appointments
- Aiding in the treatment of the mentally/physically disabled or medically compromised patient
- Reduction of gagging
- Potentiate the effect of other sedatives

SECTION 7

RULES OF THE TENNESSEE BOARD OF DENTISTRY

TENNESSEE DEPARTMENT OF HEALTH
COMMUNITY HEALTH SERVICES
ORAL HEALTH SERVICES SECTION

Following are hyperlinks to access the Rules of the Tennessee Board of Dentistry:

I. **GENERAL RULES:** Rules of the Tennessee Board of Dentistry

II. **PRACTICE OF DENTISTRY:** Rules Governing the Practice of Dentistry

III. **PRACTICE OF DENTAL HYGIENE:** Rules Governing the Practice of Dental Hygienists

IV. **PRACTICE OF DENTAL ASSISTING:** Rules Governing the Practice of Dental Assistants