GREETINGS

I would like to take this opportunity to personally welcome all clinical students for the 2013-2014 clinical and academic year. I hope everyone had a restful and enjoyable summer, and you are returning to school with positive attitudes, renewed eagerness, and determination to make this an extremely productive clinical year.

The Cooperative Clinical Management Program is the driving force for our clinical program. This program was developed to ensure many aspects of our clinical program. Foremost in the design of the program is to ensure student accountability which will ensure timely progression of students in the clinical program and increase the number of students receiving their degrees on commencement day. This program will also promote timely progression of patient treatment in a comprehensive care model. Going into the fourth year of this program, we expect the same level of cooperation from students, faculty and staff for the success of this program.

These two clinical years are extremely critical in the development of your chosen profession. It is the administration and faculty’s wish that every clinical student will be diligent, honest, and exhibit a professional demeanor in their behavior and work ethic. A competent and skilled individual in this profession has developed varied clinical abilities. To complete your competency in dentistry, you must during these clinical years develop patient management and communication skills.

Along with your clinical skill development, now is the time to learn and develop sound ethical professional behavior in this profession. You must believe and realize that incidences of unethical unprofessional behavior will most certainly jeopardize your dental school matriculation. Many dental practices have been forced to close due to unethical behavior outside the practice of dentistry, as well as practicing dentistry in an unprofessional manner.

You are fortunate to have an excellent, skilled and devoted faculty that are more than willing to assist you with your success during these clinical years. Please don’t hesitate to seek their wisdom and guidance. Use their talents and experiences to the best of your ability.

Best of luck to all of you during this year and if the Office of Clinical Affairs can be of any assistance to you, please feel free to call or come by at any time.

Dr. William D. Scales
Associate Dean for Clinical Affairs
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Purpose

The Student Clinic Manual serves as a guide for the daily clinical activities of the student. The clinic manual details clinic policy and procedures related to all activities in the clinical program. Additionally, the manual is designed to orient the dental student to clinical dentistry, as well as to serve as a ready reference on information about the various departments. It is the responsibility of the student to become familiar with each aspect of the clinic manual to facilitate clinical problem-solving during his/her clinical years at the dental school. It is expected that this manual will also serve as a ready reference for clinical decision-making in years subsequent to graduation.

Philosophy of Patient Care

In the dental clinics, Comprehensive Dental Care is defined as a system of clinical instruction and operations which permit the student to provide, or be responsible for, all aspects of a given patient's dental treatment needs in a manner that closely resembles the way the student will provide care in a private practice subsequent to graduation.

The concept of comprehensive care forms the foundation for all clinical treatment within the School of Dentistry. This concept is facilitated by two basic approaches including comprehensive patient care and specialty rotations. This broad-based approach enhances the environment in which high quality dental health care can be delivered in a more humanistic manner by students. It is expected that in using this dual approach to care, the barriers, which delay high quality care, will be removed. Systematic treatment planning and a patient referral system permit the student to become aware of the needs of the patient and the skills required to satisfy these needs.

The School of Dentistry retains the sole authority and responsibility for its operations. Patient care rendered by student practitioners is provided under the direct supervision of licensed faculty members. All dental procedures rendered by student providers must be performed under direct supervision of a licensed faculty member and must be evaluated and approved prior to and during service provision. Periodic and final evaluations are required prior to reappointment and patient dismissal. The supervising faculty must ensure that each clinical procedure and patient encounter is appropriately documented in the AxiUm software and approved by a faculty person evaluating the procedure(s).

Conditions of Treatment

The School of Dentistry is one of four academic teaching units at Meharry Medical College. In the School of Dentistry there are four levels of providers available for patient care:

1. The undergraduate dental students
2. The postgraduate general practice residents
3. The postgraduate oral and maxillofacial surgery residents
4. Faculty providers

Options for care are based on patient choice, time availability of patients, their ability to pay for services, and the complexity of treatment. Initial assessment and provider group assistance is facilitated by the Department of Oral Diagnostic Sciences.
1. Type of dental treatment needed - Treatment must be within the scope of the undergraduate student's ability to conform to the educational objectives of the institution; i.e., patients whose dental needs permit undergraduate students to provide high quality comprehensive care, attain a broad clinical experience, and to meet their clinical competencies will be accepted in the undergraduate clinical program. Patients requiring more advanced treatment will be referred to the resident program.

2. The availability of the patient - The patient assigned to the undergraduate student must be able to attend the clinics during regular hours of operation: 8:00 AM - 5:00 PM, Monday - Friday.

3. Patient's ability to pay for services rendered - Patients should be able to pay for services rendered at each appointment. Fees for service rendered by undergraduate students and resident differ. Students are prohibited to pay for patients services.

4. Patient's health status - Persons with severe medical conditions may pose problems that are not within the scope of the undergraduate student. These patients will be referred to the residency program.

Fees for services in the School of Dentistry are not based on profit; however, operational costs and/or other overhead costs must be generated. A non-refundable registration fee (examination fee) of sixty ($60.00) dollars will be charged.

**NOTE:** MEHARRY MEDICAL COLLEGE SCHOOL OF DENTISTRY RESERVES THE RIGHT TO DETERMINE SUITABILITY OF PATIENTS FOR TREATMENT IN ITS CLINICS.

Patients Types Based on Care Sought

**Preventive Care Patients**

These patients are seeking preventive care only and will be treated by dental students. If accepted for treatment, the patient record is prepared and the patient receives a clinical examination, detailed review of the medical history, and an appropriate radiographic survey. The patient is assigned to a student, the Comprehensive Treatment Plan is formulated, and the fees are assessed and discussed with the patient.
Emergency/Urgent Care Patient

These patients are seeking emergency or urgent care for the relief of pain or other services that necessitate immediate attention, i.e., broken dentures, etc. These patients may be categorized into three types:

1. **Patients not registered in the clinical program.** These patients must register; pay the emergency fee, have a screening history and radiographic survey completed. A diagnosis and limited treatment plan with Consent Form is reviewed within the Oral Diagnosis Clinic. The patient is then treated in the Emergency/Urgent Care Clinic located in the Oral Diagnostic Sciences Clinic or referred to the post graduate program. Fees for services are assessed as treatment progresses. The patient will receive only the treatment necessary to eliminate pain or other designated urgent care problem. The patient is encouraged to seek further treatment beyond the emergency treatment plan outlined by the student, fees are assessed, financial arrangements are made and the patient enters the clinical program as a regular patient.

2. **Those patients who are currently assigned to a dental student and present for emergency care.** The student to whom the patient is assigned is responsible for the care of the patient. The assigned student may refer the patient to a specialty area for treatment or be assisted in the evaluation and treatment of the patient by an instructor in the appropriate department. If the student currently treating the patient is not available, the patient may be referred to another student or to the involved department. In the event, the patient will return to his/her assigned student once the immediate care has been terminated. Fees for services rendered will be assessed and collected based on the provider level (ex: Graduate Programs).

3. **Patients seeking emergency care after clinic hours, during weekends or summer recess will be referred to the General Hospital Emergency Room for evaluation.**

**Comprehensive Care Patient**

**New Patient**

This patient is seeking complete care to maintain his/her oral health and is placed in our Cooperative Clinical Management Program for student assignment.

**Return Patient**

A returning patient presenting to the clinic will sign-in at the front desk (PSR station 1st floor). The PSR will check-in the patient in the AxiUm clinical software program and follow the returning patient’s day of appointment process.

**MEDICALLY COMPROMISED PATIENT**

Medically compromised patients will be classified into five categories according to the medical risk (physical status) classification of the American Society of Anesthesiology.
Class I
A patient without systemic disease. The pathologic process for which the operation is to be performed is localized and not conducive to systemic disturbance.

Class II
A patient with mild to moderate systemic disease caused either by the condition to be treated surgically or by patho-physiologic processes i.e., the patient with essential hypertension, mild diabetes which is under control.

Class III
A patient with severe systemic disease that limits activity, but is not incapacitating; i.e., the patient with uncontrolled diabetes, severe coronary artery disease, dialysis, anticoagulant therapy, etc.

Class IV
A patient with incapacitating systemic disease that is a constant threat to life.

Class V
A moribund patient not expected to survive twenty-four hours with or without operation.

Undergraduate dental students may treat Class I and Class II patients, and Class III patients upon approval of faculty attendant at the treatment planning appointment with necessary consultations. Post-graduate dental students (residents) may treat Class I, Class II and Class III patients with necessary consultations. Class IV and Class V patients will be treated in a multidisciplinary manner under hospital conditions by specially trained practitioners.

Physician Consultations

When it is necessary to secure medical information and/or clearance prior to completing the oral diagnosis process and treatment itself, the students and faculty may: 1) contact the physician by phone and document his or her recommendations in the progress notes, 2) complete a "Medical Consultation Request" form and have the patient take the form to his/her physician for completion and return it to the College; or, 3) complete the request form and fax or mail this form to the physician. Once a reply is received, the Administrative Assistant in the Oral Diagnostic Sciences Department will scan the completed form into the patient record and notify the student via axiUm e-mail.

Clinic Attendance

CLINICAL ATTENDANCE IS MANDATORY. Students will report to the clinics immediately after classes have been dismissed each day. Those students who are not on a service rotation, or working on a scheduled patient will report to the Patient Service Representatives Coordinator for morning and afternoon assignments. If the patient is a “no show” the student should report to the PSR Coordinator for assignment.

Clinic Cleanliness

It is the responsibility of faculty, students, and staff to keep the clinics clean by overseeing their own clinic areas and calling Campus Operations or Environmental Services as well as submitting
repair work orders as needed. Eating or drinking in any clinical area is not permitted. The use of tobacco products is not permitted in the College.

**Clinic Hours**

The dental clinics operate from 8:00 a.m. to 5:00 p.m. for dental students, excluding announced holidays, semester breaks and various scheduled special events during the school year. Post-doctoral clinics may set their individual clinic open times and each area should be consulted for its scheduled hours. Students may request patient appointments only during scheduled clinic hours and all clinic procedures must be supervised. *Treating patients without faculty supervision is grounds for suspension of clinic privileges and may result in a recommendation for the dismissal of the student.*

**Student Clinical Attire Regulations**

The dress code for the School of Dentistry is intended to establish standards of dress of constituencies, to promote professionalism, and to meet internal and external safety and infection control standards. Compliance with dress code policies is mandatory. Administrative action will be taken for noncompliance.

1. All students engaged in clinical activities will wear clean, neatly pressed scrubs and disposable gowns. The scrubs will be individually identified by name. Disposable gowns are not to worn outside the clinical setting, out of the school, or taken home. They are to be deposited in the hazardous waste containers located in the student clinic. Barrier triads of face mask, gloves, and protective eyewear must be worn in *ALL* treatment settings with patient contact.

2. Barrier triads must be worn in the laboratory setting where rotary instruments and aerosol generating tools are in use. Long lab coats will be worn, and reserved for lab work. They must not be worn into clinical areas where patient care is being undertaken. Barrier triads will be worn for all patient care encounters.

3. Nails must be trimmed and clean. Nails should not exceed the tips of the fingers so as not to cut gloves. Shoulder length hair must be pulled back or covered with a bouffant cap.

4. Tee shirts (if visible) under scrub tops must be white only with no visible print.

**Non-Clinic Attire (All Dental School Constituents)**

**Female Attire:** Dresses or skirts at the knee or longer with hosiery, along with shoes 2 – 2 1/2 inch heels, slacks and shorts at the knee or longer with hosiery are considered to be appropriate attire for women. Clean, neatly pressed scrubs are acceptable classroom attire for junior and senior dental students *ONLY*.

Earrings should be conservative and appropriate for business attire. Hair should be neat and well groomed. Good personal hygiene should be adhered to at all times.
Male Attire: Shirts with ties, turtleneck or crew neck sweaters, band collar shirts (buttoned) and slacks are considered appropriate attire for men. Hair should be neatly cut; beards and mustaches well-groomed. Good personal hygiene should be adhered to at all times. Clean, neatly pressed scrubs are acceptable classroom attire for junior and senior dental students ONLY.

Basic Science Courses: Clean, comfortable clothing is permitted for basic science lectures. Separate attire is permissible for gross anatomy laboratory. Regular dental school attire must be worn in the dental school. Good personal hygiene should be adhered to at all times.

Prohibited Attire

1. Jeans
2. Open-toed shoes and sandals with hosiery/socks in the classroom
3. Shorts of any type
4. Revealing tops for women (low cut, see through blouses)
5. Miniskirts (women), tight clothing
6. Dresses/skirts - deep slits (women)
7. Disposable gowns except in clinical areas
8. “T” shirts as an outer garment
9. Canvas shoes, open-toed and sandals in the clinic
10. See through lace, chiffon or similar blouses, spandex or other tights
11. Loosely fitting bracelets, necklaces or rings
12. Earrings and necklaces outside the tie or shirt (men)
13. Caps, hats, and other head wear

Section 1.01 Clinical Policies in the School of Dentistry

A. Patient appointments are made and cancelled if necessary, by the Patient Service Representative, students will not be allowed to cancel patient’s appointments.

B. Students must treat all patients that are assigned to them by the patient service representative and must do so every two weeks or sooner. Any violations of this will result in the patient being reassigned to another student. Students are not permitted to refuse any patient that is assigned to them. Those students that refuse to accept a patient that is assigned to them or is not on a service rotation at the scheduled time will be suspended from the clinics for three days.

C. All students must wear clean well pressed clinic scrubs and disposable clinic gowns. Disposable clinic gowns are not to be worn on the streets or outside the School of Dentistry. Faculty, staff and students must strictly adhere to the School of Dentistry’s dress code as stated in this manual.

D. Student conduct will be monitored by all faculty, particularly by the Associate Dean for Clinical Affairs.

E. The Associate Dean for Clinical Affairs will access a clinical grade based on attendance and recommendations from clinical department chairs. This grade will be based on your timely
progression of patient care and your management of patients. The grade will be Pass (P) or Fail (F).

F. All completed treatment; Procedure notes and S.O.A.P. notes must be entered into the AxiUm clinical software program and approved by a faculty member. All entries should be made within 48 hours of patient treatment. Failure to adhere to the correct protocol will result in clinical disciplinary actions.

Violations of any of the above items A-F may result in the following disciplinary action.

1. Three (3) day suspension from the School of Dentistry which means you will not be allowed to see your assigned patients, but you will be required to complete a special project in the department in which you are to report.

2. Seven (7) day suspension from the School of Dentistry and all clinical activity.

3. Recommend to the Dean, School of Dentistry immediate dismissal from the School of Dentistry

The above disciplinary actions are not based on the first time through a third time offense, but on the frequency and severity of the violations incurred by the student. If the action is considered severe enough, the student may be recommended for dismissal from the School of Dentistry after the first offense.
WE BELIEVE ..... 

THE School of Dentistry and ALL its students and employees are obligated:

TO provide you with good, considerate, courteous care which recognizes your dignity and needs as a fellow human being in need of dental care.

TO protect your right to privacy and to keep your records and needs as a fellow human being in need of dental care.

TO provide treatment without discrimination as to race, color, religion, sex, national origin, disability, sexual orientation or source of payment.

TO respond promptly and courteously to any reasonable requests for service which do not conflict with acceptable standards of care.

TO provide you, upon request, the name of any person providing you treatment and/or care and his/her relationship to the School of Dentistry.

TO provide you with the option to refuse treatment and be told what effect this may have on your health.

TO provide you with a mechanism by which you can complain without fear of reprisals about the care and services that you receive.

TO be generally sensitive to your needs and to respond in a prompt and reasonable manner to any complaints you may have.

TO provide access to care for emergency situations by calling 615-327-6669 during normal business hours or 615-341-4357 after normal business hours

TO provide you prompt and accurate answers to any questions you may have concerning any fees.

TO provide you with a copy of your dental record for which a reasonable fee can be assessed upon written request.
**THE STUDENT DENTIST AND FACULTY ARE OBLIGATED:**

TO provide you with understandable information, as deemed appropriate in consideration of your health status, concerning your diagnosis, treatment and the probable outcome of your condition.

TO provide all information needed to give informed consent before beginning any proposed procedure or treatment. This information shall include the possible risks, benefits, and cost of the procedure or treatment.

TO fully inform you of the need to transfer you to another provider or facility and the alternative to such a transfer.

TO permit you to decline any treatment and fully inform you of any possible consequence which could result from such action.

TO recommend consultation with other dental care providers when indicated.

TO discuss with you any questions concerning services.

TO provide you reasonable continuity of care while a patient in our clinics.

**THE PATIENT IS OBLIGATED:**

TO the best of his/her ability, keep all appointments or

TO try to contact the Patient Service Representative at the School of Dentistry 24 hours ahead of the scheduled time if the appointment cannot be kept.

TO follow, to the best of your ability, all reasonable instructions prescribed by your student/faculty dentist or question any instruction you do not understand.

TO provide accurate information concerning your health, medical history and past hospitalization(s).

TO be responsible for the cost of all dental services rendered.

TO discuss and make all payment arrangements with representatives of the Business and Finance Office ONLY.

TO maintain all receipts.

TO protect your personal property at all times.

TO contact the associate dean of clinical affairs, or the associate dean of business and finance, to discuss any questions concerning charges for services or complaints that you might have.
The Dental School respects patient confidentiality by maintaining records in a secure area; restricting access to authorized individuals and agencies; and releasing information per patient/family request.

**NOTICE OF PRIVACY PRACTICES**

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

You have the right to obtain a paper copy of this Notice upon request.

<table>
<thead>
<tr>
<th>Patient Health Information</th>
<th>Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.</th>
</tr>
</thead>
</table>
| Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. | **Article II. Special Uses**

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you. |

<table>
<thead>
<tr>
<th>How We Use Your Patient Health Information</th>
<th>Other Uses and Disclosures</th>
</tr>
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<tbody>
<tr>
<td><strong>We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.</strong></td>
<td><strong>We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:</strong></td>
</tr>
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<tr>
<th>Examples of Treatment, Payment, and Health Care Operations</th>
<th><strong>Required by Law</strong>: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.</th>
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<tbody>
<tr>
<td><strong>Treatment</strong>: We will use and disclose your health information to provide you with medical/clinical treatment or services. For example, nurses, physicians, dentist and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.</td>
<td><strong>Public Health Activities</strong>: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.</td>
</tr>
</tbody>
</table>

| **Payment**: We will use and disclose your health information for payment purposes. For example, we may need to obtain | **Health Oversight**: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities. |
authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.

- **Judicial and Administrative Proceedings:** We may disclose information in response to an appropriate subpoena or court order.
- **Law Enforcement Purposes**: Subject to certain restrictions, we may disclose information required by law enforcement officials.

- **Deaths**: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

- **Serious Threat to Health or Safety**: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Military and Special Government Functions**: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

- **Research**: We may use or disclose information for approved medical research.

- **Workers Compensation**: We may release information about you for workers compensation or similar programs providing benefits for work-related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

**Individual Rights**

You have the following rights with regard to your health information. Please contact the person listed below to obtain the appropriate form for exercising these rights.

- **Request Restrictions**: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

- **Confidential Communications**: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of appointments.

- **Inspect and Obtain Copies**: In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.

**Amend Information**: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

**Accounting of Disclosures**: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

**Our Legal Duty**

We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect.

**Changes in Privacy Practices**

We may change our policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the waiting area and each examination room. You can also request a copy of our Notice at any time. For more information about our privacy practices, contact the person listed below.

**Complaints**

If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

**Contact Person**

If you have any questions, requests, or complaints, please contact:

- **Title**: Compliance/Privacy Officer
- **Address**: 1005 Dr. D.B. Todd Jr. Blvd
  - Nashville, TN 37208-3599
- **Number**: (888) 695-1534
- **Email**: compliance@mmc.edu

You may also send a written complaint to the United States Secretary of the Department of Health and Human Services. Contact information can be found at the website for the Office of Civil Rights at www.hhs.gov/ocr.
Effective Date: The effective date of this Notice is 4/14/2003
This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this Notice upon request.

**Patient Health Information**

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

**How We Use Your Patient Health Information**

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information even without your permission.
Cooperative Clinical Management Program

PURPOSE: Cooperative management is a gateway program designed to allow the dental school to assume a more pro-active management role in all administrative and operational aspects of the student’s clinical experiences. This program represents a paradigm shift in the level of support of student clinical experiences. Specifically, the Cooperative Clinical Management Program is designed to:

- enable students to meet clinical experiences in a timely manner
- enable students to assume responsibility for comprehensive patient care
- ensure student accountability by maximizing utilization of clinic resources
- ensure adequate and equitable distribution of clinical patients to students
- ensure payment for services rendered
- ensure clinical services follow the treatment plan and sequence
- ensure effective use of the AxiUm clinical software
- ensure an effective recall appointment system

OPERATION: The Cooperative Clinical Management Program coordinates the efforts of Patient Registration, New Patient Orientation, Appointment Scheduling and Cancellations, Patient Assignment, Financial Counseling, and the various Departments responsible for clinical treatment. To direct the efforts of these entities toward maximum utilization of clinical resources, clinic management support teams are located on the 1st and 4th floors. The clinic management team is directly responsible for assisting each dental student in the day-to-day administrative and operational clinical activities.

The 1st floor management team will consist of two (2) Patient Service Representatives (PSRs). The PSRs will be responsible for new patient registration, update of patient demographic information, appointment scheduling, and patient check-in and check-out, present clinic orientation to new patients and assist in receipt of patient payments.

In addition, Billing Personnel are located on the 1st floor. They are responsible for receipt of patient payments, financial counseling, submission of third party claims, and establishing payment plans.

The 4th floor management team consists of two (2) Patient Service Representatives. The PSRs will be responsible for appointment scheduling and cancellation, patient check-in and check-out.

A Patient Service Representative Coordinator will coordinate the activities of the PSR’s on both the 1st and 4th floors. The PSR Coordinator will in addition make alternate daily clinical assignments for student whose patient cancels or no-show, and maintain daily/weekly and monthly reports in AxiUm.

This management team will enable each dental student to participate in one of the traditional patient treatment settings (regular treatment clinics, emergency clinic, or service rotations), or perform simulated patient treatment exercises each day.
Patient checks in front desk → Patient Service/Financial Representative

Check HIPPA, consent form, etc. → Payment Received

Payment Received → Patient will remain in lobby for student pick up

Student will initial sign-in log and proceed to clinic → ODS CLINIC

Radiographs → Patient receives pre-op check

Student enters and completes treatment, procedure and SOAP notes → Faculty

Approves treatment and SOAP notes in AxiUm. Patient is escorted to their restorative clinic for treatment planning

Sign HIPPA, consent form, etc. → Patient checks out/return appointment → Meet with Business Office (As needed)

Patient Service/Financial Representative → Financial Counseling
School of Dentistry

08/20/2011

Returning Patient

Patient Service/Financial Representative

Checks in front desk →

Update demographics, HIPPA, and consent form, Etc.

Patient Service/Financial Representative

PSR verify treatment and SOAP Note entry
Patient checks out/return appointment

Student completes treatment and SOAP Note in Axium

FACULTY
Reviews and Approves treatment and notes in Axium

VARIOUS CLINICS

Payment Received

Payment Received (if Needed)

Student receives pre-op check

Student will remain in lobby for student pick up

Student will initial sign-in log and proceed to clinic

Students will check in With PSR.
PATIENT SERVICE REPRESENTATIVE (PSR)

I. The PSR’s Responsibilities

A. The PSR will help schedule appointments for dental patients when students are not available.

1. Give your PSR’s name and telephone number to your patients so they can help schedule appointments.

2. Appointment requests are to be made through the AxiUm email system. The PSR will utilize the information you enter in the computerized appointment system to produce your personalized day sheet of appointments.

3. All appointment requests must include:
   a. the procedure name, procedure code and tooth number
   b. the discipline (Perio, Fixed, Removable, OMFS, Endo, Emergency, Operative, Implantology, ODS, etc.)
   c. premedication requirements
   d. estimated fees for the procedure
   e. assigned instructor if applicable

4. The PSR will help arrange for the student’s appointments in all of the discipline clinics.

5. The PSR will try to fill broken or cancelled appointment in a timely manner.

6. The PSRs will help to confirm appointments 1-2 days in advance.

7. The PSR will record all no shows, cancellations and late arrivals in the patient record. 15 – 30 minutes past the scheduled appointment time is considered a late arrival.

8. The PSR will process all appointment requests within 24 hours unless the patient cannot be reached. The PSR will attempt to contact the patient three times. This information will be documented in the patient’s EHR contact notes section.

B. The PSR will monitor student activity in the clinics

1. The PSRs will maintain a roster of all assigned patients and assist in monitoring the frequency of treatment.
C. The PSR will provide feedback to the PSR Coordinator and the Office of Clinical Affairs on issues of professionalism that pertain to the PSR/student working relationship.

II. The Student’s Responsibilities

A. Appointments

1. **Schedule appointment requests via AxiUm.** You may make your axiUm request at chairside, or at any axiUm computer. You may personally escort your patient to the PSR appointment desk and request the next appointment.

2. **Do not instruct patients to call the PSR to set up an appointment** until you have entered the patient request via the AxiUm e-mail system.

3. Give each patient the name and telephone extension of your PSR. Once you and the PSR have agreed that the PSR will make the appointment, allow the PSR to do so. To schedule in any other manner may result in double booking of patients.

4. **The student should furnish appointment requests in axiUm** well in advance of school breaks.

5. The student must fulfill each department’s requirement for scheduling of patients in the clinics, (i.e., consultation with proper faculty, obtaining medical consults, etc.)

6. Make appointments or submit appointment requests well in advance. Otherwise, there may not be a chair available.

7. Remind the patient to check in with the PSR when they arrive for an appointment.

B. Procedure Code/SOAP

1. Students are responsible for entering a completed procedure code and SOAP note for each patient appointment. Information not entered within 48 hours of the patient appointment will result in the student being locked out of AxiUm until the information has been entered.

C. Other Student Responsibilities

1. Make sure that appointment requests are submitted so that patients are seen on a regular basis

2. **Check your PSR/Student communication area periodically during the day.** Any changes in your schedule or messages from patients will be put
You must inform the PSR of your whereabouts during school hours. This allows the PSR to contact you if a patient emergency occurs. Let your PSR know if you are leaving campus during unscheduled hours.

Inform your PSR if you require an assistant for a procedure. The PSRs will attempt to locate another student that is unscheduled to assist you. If a student is to assist you or if you are to assist another student or instructor, (i.e., oral surgery, endo, emergency, ODS assist), be sure the PSR has all the relevant information in the appointment request so the appropriate times are reserved.

Inform the PSR if the patient requires an on-site interpreter at least 5-7 business days prior to patient’s appointment.

Students are not allowed to serve as interpreters for patients.

SAMPLE S.O.A.P. Notes

S - Subjective – what the patient tells you
Patient’s chief complaint, history of present illness, past medical history, past dental history
Example – Patient presents states “I want to get my teeth cleaned”. Past medical history is noncontributory, however patients admit to smoking 1 pack per day of cigarettes. Past dental history – patient receives dental cleanings irregularly but brush and use floss daily.

O - Objective - what you see in your examination, including radiographs
Example – Vital signs BP 120/70, Pulse 80, Respiration 18. Intraoral exam reveals gingiva is pink and stippled with localized swelling and redness in lower posterior regions. Generalized plaque, calculus and moderate stain. Missing tooth #11. T#31 has large IRM. Extraoral exam in WNL. Radiographic exam reveals numerous restorations, carious lesions and IRM T#31. Bone lost seen in area of #18-20 and #28-32.

A – Assessment – problem list
Missing Tooth #11
Localized periodontal disease #18-20 and #28-30
Restorative treatment
Tooth #31 – Endo and Pros Consult

P – Plan – what you plan to do, and what you did today. Try to address each problem
Example – Medical and dental histories reviewed, intra and extra-oral examination completed, 14 PA and 4BW radiographs taken. Treatment plan developed and presented to patient N.V. Perio - Perio exam, OHI, S&RP (LL quad).
TIPS ON MAINTAINING A HARMONIOUS RELATIONSHIP WITH YOUR PSR

1. **Canceling or changing already scheduled appointments is unprofessional and is considered mismanagement of patients.** It will be the PSR’s responsibility to report any incidents of patient mismanagement to the PSR Coordinator and the Office of Clinical Affairs.

2. Do not instruct patients to call the PSR to set up an appointment until you have entered the patient request in axiUm.

3. **You may consult any PSR for assistance if your group’s PSR is not at the desk.**

4. Long Distance calls are permitted for patient scheduling only.

YOUR PSR WILL MAKE EVERY EFFORT TO ASSIST YOU IN EXPERIENCING AN EFFICIENT AND PRODUCTIVE YEAR.

THANK YOU IN ADVANCE FOR YOUR COOPERATION

The 1st floor registration desk is the first stop for all patients in the School of Dentistry. The registration process outlined below is meant to inform you and to help you guide patients through the process.

**Registration of New Patients:**

1. The registration process starts with an initial dental evaluation appointment in the Oral Diagnostics Clinic (ODS). A Patient Service Representative (PSR) will schedule this appointment by telephone or in person at the 1st floor registration desk.

2. The PSR will obtain financial information relative to the patients’ dental insurance if any, during appointment scheduling. There are differences in the registration process for patients with and without dental insurance. These are outlined below.

**Patients with Dental Insurance:**

1. The PSR will obtain the insurance information when making the appointment for the initial evaluation visit.

2. Patients will be advised to bring their insurance card and two forms of identification with them for their initial dental evaluation appointment in the ODS clinic.
   a. A valid driver’s license, social security card, student or employment ID, or a copy of a current utility bill with the patients name and address are acceptable forms of ID.
b. The PSR will inform the patient that the insurance co-pay and/or deductible must be paid on the initial evaluation appointment in the (ODS) clinic. The Office of Business and Finance will determine the co-pay amount.

**Patients with no dental insurance:**

Patients without dental insurance will be informed by the PSR that a fee of $60.00 must be paid when presenting for the initial evaluation appointment in the ODS clinic. The fee is for a complete set of radiographs consistent with patient needs and initial examination.

**CLINICAL EXPERIENCES**

The concepts of comprehensive dental care forms the foundation for all clinical treatment within the dental school. This concept will be facilitated through two basic approaches: comprehensive patient care and specialty rotations.

**Comprehensive Care**

Students will be expected to manage the complete treatment of patients assigned to their care. As experience is basic to clinical competence, a specified number of clinical experiences must be completed in the junior year prior to advancement to the senior year. Specified clinical experiences must also be completed prior to graduation. Completion of all patients needs is always stressed during the clinical tenure for both junior and senior students. Dental students will also be given the opportunity to provide comprehensive care through interaction with dental practitioners in an off-campus environment similar to the private and/or public dental milieu.

**Specialty Rotations**

The clinical experience of the pre-doctoral student is expanded in scope with a rotation through the specialty areas of dentistry for a specified period of time. The concept of the specialty rotations includes the following:

1. General Practice Residency Clinic
2. Oral Diagnosis/Radiology Clinic (OD/RAD)
3. Oral Surgery (OS)
4. Pediatric Dentistry
5. Emergency Clinic
6. Restorative Sciences (Implantology)

**Patient Assignment**

Patients who are recruited by a student will be assigned to that student when the patient’s name is given to registration when scheduling the screening appointment.
Patients will be assigned to a student in such a manner that patient satisfaction is assured and the clinical needs of the student are met. Patients will be placed in a patient pool and assigned by the PSR Coordinator. Students requiring specific needs (i.e., classes of patients) must sign up on the patient's need list with the Office of Clinical Affairs (PSR Coordinator).

**The Initial Dental Evaluation Appointment:**

Patients will be advised to arrive 30 minutes (7:30 am/12:30 pm) for the start of their appointment to allow time to fill out the necessary dental registration and financial forms and to participate in New Patient Orientation.

1. Patients will be greeted at the registration desk and asked to sign in on the New Patient Log by a PSR.

2. Patients will be given Patient Registration Forms, HIPAA regulations information and financial policy forms to complete.

3. Patient demographic information will be entered into the AxiUm. The patient will be instructed to electronically sign the Consent for Treatment and Acknowledgement of Receipt of Privacy Forms. The patient will be checked-in AxiUm by the PSR.

4. Insurance coverage is verified for those patients with insurance.

5. Student recruited patients will be coded by the PSR.

6. The patient will be instructed to pay fees outlined above. The patient will then be directed to the 1st Floor Conference Room for New Patient Orientation upon completion of the orientation, the patient will be directed to the lobby to wait for their appointment with the assigned student.

7. The PSR will notify student that the patient is ready for the exam. Student will initial the sign-in log indicating patient pick-up.

**Returning Patients with Appointments:**

- Returning patient is greeted by PSR and asked to sign the Returning Patient Log.

- All financial obligations must be met prior to appointment.

- Patient is asked to complete a demographic update form, if any demographic information has changed including insurance information.

- The patient is checked-in the AxiUm system and instructed to wait in the lobby for the student.
• A student doctor meets the patient in the lobby and initials the Return Patient Log indicating patient pick-up.

• If the patient has concerns about their financial obligations, the patient is directed to the Business and Finance Office to speak with a Billing Representative. Once the problem is resolved, the Student Doctor and patient proceed to the Patient Service Representative on the 4th floor with payment receipt.

• When the patient treatment for the day has been completed, students must document all treatment in the AxiUm software program.

• The PSR will verify treatment and S.O.A.P. notes entered, make the patient a return appointment and check the patient-out for the day’s visit.

• The Associate Dean for Clinical Operations coordinates all the activities of the 1st and 4th floor management teams. Students presenting to the 4th floor clinics for patient treatment must first check-in with the Patient Service Representatives.

4th FLOOR OPERATION (STUDENT WITH PATIENT)

1. Patient Treatment (Student Clinics)

Clinic Faculty will:

a. Verify payment receipt
b. Review treatment record(s) with student
c. Supervise changes in treatment plan on AxiUm
d. Supervise patient treatment
e. Approve completion of treatment in AxiUm
f. Review and approve patient Procedure and S.O.A.P. notes in AxiUm
g. Review student self-evaluation of the clinical procedure in AxiUm
h. Complete faculty evaluation in AxiUm for the procedures and attendance

2. Check-out with PSR

Patient Service Representatives will:

a. Verify record of treatment and S.O.A.P. notes entered in AxiUm
b. Make next appointment and check-out patient

Students who have no patients scheduled or late patient cancellations (“no-shows”) must check-in with the Patient Service Representative Coordinator (PSR) immediately upon notification to obtain an alternative clinical work assignment. The PSR Coordinator will notify each clinic of the student(s) new assignment. This process will ensure attendance accountability for the student.
4th FLOOR OPERATION (STUDENT WITH PATIENT NO-SHOW OR CANCELLATION)

1. Check-in with PSR Coordinator

Patient Service Representative Coordinator will:

a. Check the student clinic record for no-show or cancelled approved documentation by faculty
b. Check the status of alternative clinics with respective clinic/faculty
   i. Assign student to emergency clinic
   ii. Assign student to Dent Sim Lab
   iii. Assign student a GPR/OS service
   iv. Assign student to assist other students in clinics (ODS, Radiology)

2. Check-in with assigned faculty

Students will:

a. Document in AxiUm no show or cancellation
b. Request faculty approval (swipe) of their progress note indicating no show or cancellation
c. Allow patients 30 minutes prior to cancelling appointment.

3. Check-out with PSR

Patient Service Representatives will:

a. Verify appointment cancellation documentation in axiUm by student
b. verify next treatment/appointment
c. Make next appointment

4. Emergency, GPR/OS Clinics, ODS Clinics, Sim Lab

Clinic Faculty will:

a. Swipe the start attendance code entered by the student
b. Supervise treatment
c. Approve completion of treatment and attendance in AxiUm
d. Approve procedure and SOAP notes in AxiUm

STUDENT RESPONSIBILITIES: The delivery of quality dental care requires a combination of many skills. Among these are: good time management, effective communication with patients, staff, and colleagues as well as knowledge of the biologic sciences, dental disease and treatment. The Cooperative Clinical Management program is intended to aide in the mastery of time management, communication and patient management. Moreover, the system will help students to progress through the two clinical years of dental school with the greatest possibility of meeting the clinical experiences and graduating on time.
You will be required to assume a level of responsibility that you may not have experienced. However, this management system will foster an easy transition to dental practice and/or a postdoctoral training program. The program addresses three major themes:

Time management

a. Faculty will provide clinic coverage from the hours of 8:00 a.m. to 12:00 noon and from 1:00 p.m. to 5:00 p.m. Students are expected to be present and on-time for all clinics. Faculty will be available for teaching and student/patient assistance from 8:00 a.m. to 11:00 a.m. during the morning clinic session and from 1:00 p.m. to 4:00 p.m. during the afternoon session. Students are expected to seat patients within one-half hour after the clinics open. All clinical patient services must be completed by the deadline. (11:00 am and 4:00 pm)
b. Faculty will be available from 11:00 a.m. to 12:00 noon for signatures and to log in, on the e-records, treatment services rendered during the morning session. All grading and signatures must be completed before 12:00 noon. Similarly, faculty will be available from 4:00 p.m. to 5:00 p.m. for signatures and to login treatment services rendered during the afternoon session. Student self-evaluations and faculty evaluations of all clinical procedures must be completed before 5:00 p.m.
c. Students who are late or who have late patient appointments will not be allowed to start clinic procedures unless prior approval has been obtained from the faculty assigned to the clinic floor and depending on patient arrival times, students with guidance from faculty may be instructed to select alternative treatment for the patient for that day.
d. Know the procedure you will be performing before the appointment.
e. Be familiar with the patients’ medical and dental history and the dental implications.
f. Have the dental unit prepared according to infection control guidelines as outlined in the clinic manual and have the proper set of instruments available for patient examinations.
g. All instruments must be submitted to central sterilization before 5:30 p.m.

2. Communication skills

a. Check the patient appointment in AxiUm at least twice daily for patient appointments
b. Work with the clinic management team and coordinate your patient management and clinic appointment time with the PSR.
   i. You are required to inform your PSR when you have a “no show”
   ii. When informed of your new clinical activities, report promptly to fulfill the assignment.
c. Be prepared to explain each treatment procedure to your patient in terms that the patient will understand
d. Be alert for patient discomfort or distress either before, during or after treatment and respond appropriately.
e. You must get permission (start check) from the clinical faculty to start patient care and you must be prepared to discuss the treatment procedure and the rationale.
f. You must get permission from the clinical faculty to dismiss your patient.
3. **Comprehensive patient care and patient management**

   a. All patients accepted for dental care at Meharry Medical College will receive comprehensive dental treatment.
      i. The most important person in the comprehensive treatment planning team is the patient.
      ii. Comprehensive treatment is a process involving interaction between the patient and clinician.
      iii. Many factors influence the treatment plan making it dynamic; it is not a static list of carious teeth and restorations.
   b. You are required to fulfill all of the treatment needs of all of your assigned patients.
      i. Patients cannot be passed from one student to another for treatment procedures without permission from the Associate Dean for Clinical Affairs. Students are required to submit a Student Encounter Advisement form.
      ii. PSR Coordinator will record the history of the limited care transfer in AxiUm.
   c. Treatment must progress in the sequence delineated in the treatment plan.
   d. Changes in the treatment procedures or sequence are allowed only after discussion with your instructor and patient. The alteration and the rationale must be recorded in the AxiUm system and approved by the clinical faculty.
   e. All contacts with patients must be recorded in the AxiUm including phone calls, treatment rendered, and discussions with the patient regarding changes in treatment, and consultations with faculty or the patient’s physician.

**FACULTY RESPONSIBILITIES:**

- Faculty will review medical history and planned daily treatment. Give the student a start-check to begin treatment.
- Faculty will review treatment records and supervise changes in treatment planning needed.
- Faculty will supervise and approve completion of treatment in AxiUm. (Procedure codes will be changed from ‘P’-planned to either ‘C’-completed or ‘I’ – in progress).

Faculty will review and approve procedure, attendance and SOAP notes completed in AxiUm per clinic session, and ensure the patient disposition is accurately recorded.

- Faculty will be responsible for informing the office of the associate dean of clinical affairs of student violation of the clinical program.
- Faculty will report to the office of the associate dean of clinical affairs all students not reporting to scheduled rotation service.

**SUPERVISION:**

The Cooperative Clinical Management Program is under the direct supervision of the office of the associate dean, for clinical affairs. Students failing to follow any aspects or guidelines of the Cooperative Clinical Management Program may result in:
**First Offense:** The associate dean, for clinical affairs will issue a written letter of warning to the student and copy placed in the student file.

**Second Offense:** The associate dean, for clinical affairs will impose a two (2) consecutive day’s suspension from normal clinical activities. During the suspension period, the student will be assigned to an alternative clinical program designed in conjunction with the department chair. Alternate assignment may include additional clinical rotations and or pre-clinical experiences to address student deficiencies.

**Third Offense:** The associate dean, for clinical affairs will impose a five (5) consecutive day suspension from normal clinical activities. During the suspension period, the student will be assigned to an alternative clinical program.

**Fourth Offense:** The student will be referred to the Student Disciplinary Committee for further disciplinary actions which may result in dismissal from the School of Dentistry.

**State and Regional Board Licensure Requirements:**

**Operative, Prosthodontics, and Periodontics**
Successful completion of three final competency examinations requirements in Operative Dentistry, Prosthodontics, Endodontic and Periodontics will qualify the student to participate in any state/regional board examinations. If the student has applied to participate on a state/regional board examination which tests the candidate for licensure in any other discipline(s), the student will be required to successfully complete the FCCE in that discipline as a qualifier to take the state/regional board examination.

**Quality Assurance Program**

As a component of the Quality Assurance Program established under the auspices of the Office of Clinical Affairs, the Quality Assurance Program has been implemented to assist the various clinical disciplines in the provision of efficient and effective quality dental services.

The School of Dentistry conducts a formal system of quality assurance for the patient care program based on the standards of care that are measured by department chairs, faculty/student assessment of care, audits, chart audits, clinical examination of a random sample of patients, patient surveys, exit exams and post treatment exams. Policies, procedures, corrective action and follow-up measures are in place for patient care and program improvements. The School’s Standards of Care are patient – centered, focused on comprehensive care and written in a format that facilitates assessment with measurable criteria. The Associate Dean of Clinical Affairs and the Director of Quality Assurance has the responsibility for:

1. Development of clinic policies and procedures
2. Assessment of patient care and satisfaction (quality assurance/risk management)
3. Assuring compliance with federal, state, local, institutional and professional guidelines and standards.

**EVALUATION PROCEDURES**

The daily clinical evaluation, practical and Final Clinical Competency Examination (FCCE) used in the evaluation of students are under the jurisdiction of the chairperson of the department and/or section head.

Faculty throughout the student/patient encounter will provide teaching and continuous assessment and feedback to the student regarding student performance.

Instructors may use the AxiUm Evaluations module to assess (grade) students’ patient treatment performance. After opening the Evaluations module the instructor must select the appropriate clinic name and evaluation form. Once the assessment (grading) is complete the system will give a prompt option to print a copy of the report for the file.

**TREATMENT PLANNING**

**Screening Form**

All new patients complete a screening form. One of the screening dentists examines the patient and completes the screening form in ODS. This information is turned into the PSR Coordinator and entered on-line and provides the data bank for matching students and patients. All patients except Pediatric patients proceed through the Oral Diagnosis Sciences Clinic. Pediatric patients register and go directly to the Pediatric Clinic.

**Patient Treatment Plan**

All dental clinic patients must have a chart number and approved treatment plan presented in the computer. These treatment plans are limited and specific to the type of treatment anticipated, i.e., emergency or routing care.

A detailed treatment plan is assigned and approved by the Restorative Department faculty for patients entering through the Screening Clinic. This detailed treatment plan is added to the patient's profile and at this time the patient is assigned to a student in the computer.

**POLICIES AND PROCEDURES ON PATIENT RECORDS**

**Ownership of Record**

The dental record is the property of the dental school and shall be maintained to serve the patient, the health care providers, and the institution in accordance with legal and accrediting requirements. Records copied at the request of the patient and other third parties will include only those records of the dental school. Copies from other health care institutions, maintained in the record as well as correspondence from outside the dental school, are filed in the record for information only, and are not subject to re-disclosure.

**Authorization for Release**
The Office of Clinical Affairs personnel are the only authorized staff of the dental school for releasing dental information. They shall be informed of their responsibility to protect patient data and use it only in the best interest of the patient.

Request for Information

All requests for dental information are to be directed to the Office of Clinical Affairs. A properly completed and signed authorization is required for release of all medical/dental information.

Telephone requests shall only be honored when the requester is a health care provider/agency currently involved in the patient’s care. These requests will require proper identification and verification to assure that the requesting party is entitled to receive such information. A record of the requests and information will be kept in a logbook. Written requests will be honored only if the written authorization is signed and dated by the patient within the last sixty- (60) days.

Faxing patient Information

Only authorized individuals may fax patient information. Use of faxing for the transmission of patient health information should be done only when the original documents or mail delivered photocopies will not serve.

Except as required by law, a properly completed and signed authorization should be obtained prior to release of information. An authorization or subpoena transmitted via fax is acceptable as long as it is signed and dated properly prior to transmission. Faxed information must include a re-disclosure statement, which states: “Confidential Information, not to be released to any other party.”

Removal of Record

A patient’s dental record may not be removed from the jurisdiction and safekeeping of the dental school except by subpoena, court order or in compliance of statute.

Patient Tracking

Each student has a group of patients who are referred to as a Family of Patients (FOP). All patients should be scheduled at least once every two weeks. Students who do not see their patients on a regular basis are called in to explain any unusual circumstances to the Associate Dean for Clinical Affairs; this has a definite influence on your clinic grade as described earlier. The Dean's Office is notified when obvious abuse of a patient is identified and appropriate consequences are enforced.

Student Production report is one of the primary reports used to track patients and student progress. Patients are monitored using the tracking system to determine if they are seen by the student dentist on a regular basis. Patients should be scheduled at least once every two weeks. The report is a summary list of the patients assigned to the student. It lists the patient's name, chart number and the date the patient was last seen.
Mission Statement

The Compliance and Safety component of Clinical Affairs is committed to the operation, development, and implementation of policies and procedures that address clinical disciplines in the provision of efficient and effective quality dental services.

Key Components of an effective Compliance Program

- Written standards of conduct, policies and procedures
- Personnel dedicated to ensure compliance
- Regular, effective education and training programs
- Effective processes and lines of communication between the Compliance Officer and all faculty, staff and students
- Process to audit and monitor compliance and proactively reduce issues in problem areas
- Disciplinary Enforcement
- Corrective action initiatives developed in response to detected offenses
- Providing students with a positive and diverse academic environment
- Ensuring the confidentiality of student records
- Administering quality health care while maintaining a patient’s rights to privacy (HIPAA – Health Insurance Portability and Accountability Act of 1996)
- Providing opportunities for employees to seek professional growth and development
- Ensuring proper credentialing of all healthcare professionals
- Guarding against fraud and abuse to members of the college community
- The College is committed to providing meaningful access to health care and social services to persons with Limited English Proficiency (LEP) skills by providing timely and accurate language assistance and effective communication to patients at no additional cost
- The SOD is committed to complying with all federal, state, and local laws and regulations
- No tolerance for harassment
- Substance abuse will not be allowed in the School of Dentistry. (ADA Dentist Well-Being Committee assist dentist and families with personal problems)
- Encourages the reporting of Potential Violations
- All members of the College community have an obligation to report possible violations of College policies, standards and laws
- Meharry prohibits retaliation against anyone who in good faith reports suspected violations of any laws, regulations or policies.
- The college provides various resources for individuals to report potential violations;
The Compliance Hotline:
(888) 695 – 1534
(24 hours a day, 7 days a week)
The Compliance e-mail address:
Compliance@mmc.edu

Compliance:

- Ronette Adams-Taylor, Esq. x 6552
  Associate General Counsel/Director of Compliance & Risk Mgmt.

- Jackie Brown
  Risk Management Specialist

Clinical Policies

In order to create and maintain the best possible professional atmosphere for Meharry Medical College, School of Dentistry, it is necessary that faculty and student doctors adhere to standards of professionalism, courtesy and ethics. Each faculty member should serve as a professional role model to student doctors and establish a positive rapport in all educational settings. Each student doctor should recognize their responsibility in professional growth and maintain an attitude that strengthens that development.

Primary Requirements

Infection Control requirements are based on the theory of “Universal Precautions”. This means all patients are potentially infectious. Universal precautions as defined by the Centers for Disease Control (CDC) and the Occupational Safety and Health Administration (OSHA) refer to a set of precautions designed to prevent transmission of Human Immunodeficiency Virus (HIV), hepatitis B (HBV), and other blood borne pathogens in the health care setting. Using universal precautions, “human blood and certain body fluids of all patients are considered potentially infectious for HIV, HBV and other blood borne pathogens.”

These guidelines will be adhered to by all faculty, staff, students and patients.

HEPATITIS B IMMUNIZATION

Requirement 1 “All dental health care personnel (DHCP’s) having patient contact is required to be immunized against hepatitis B.”

Rationale The OSHA Standard, 29 CFR 1910.1030, Blood borne Pathogens, requires immunization against HBV for health care providers who have occupational exposure; this would include all students, faculty and staff that have exposure to blood borne pathogens. “Blood borne pathogens mean pathogenic microorganisms that are present in human blood and can cause
disease in humans. These pathogens include, but are not limited to, HBV and HIV.” (29 CFR 1910.1030 (b).

**Waiver in lieu of Vaccination**

That faculty, staff and students who elect not to have the vaccinations must sign the waiver of vaccination in lieu of having the series of vaccinations.

**Student Responsibility**

It is the responsibility of the students to provide their own vaccination. Verification of completing the vaccination series prior to enrollment or commencement of the vaccination series within the first 4 weeks of enrollment will be monitored.

**OCCUPATIONAL EXPOSURE TO BLOOD AND BODY FLUIDS:**

**Management**

This policy is to provide standardized guidelines for the administration of post-exposure prophylaxis to dental healthcare workers and patients who have had an occupational exposure to blood and/or body fluids.

**PROCEDURES**

1. Stick with needle contaminated with blood or body fluid
2. Puncture wound with a sharp or other instrument that has been contaminated with blood or body fluid
3. Splashed or sprayed with blood or body fluid that contaminates the eyes, mouth, or other mucosal surface
4. Incidents that result in cutaneous exposures involving large amounts of blood or prolonged contact with blood, especially when the exposed skin has an open wound, is chapped, abraised, or afflicted with dermatitis.

**PROCESS**

Wound care/first aid:

- Irrigate wound with normal saline or sterile water
- Flush mucous membrane with water or saline
- Injuries requiring suturing or other intervention should be treated as usual

A. A Reportable Event Form should be obtained from the clinic dispensary and completed
B. All dental school faculty, staff, students and patient report to the Meharry Clinic Building, 3rd floor Room 331. If after clinic hours report to Metropolitan Nashville General Hospital Emergency Department
C. At the emergency room report a blood and body fluid exposure

GUIDELINES

A. Blood and body fluid exposure
   • Reportable Event Form filled out by dental school faculty, staff, student or patient
B. Degree of Exposure should be evaluated in the Emergency Room
C. Obtain “risk panel” blood work on faculty, staff, student, or patient (HIV, HBsAB, HBsAg, HCV)
D. Informed Consent: Upon admission of dental school clinics, all patients will sign a statement on the registration form that specifies permission to test for HIV and Hepatitis B in the event of an occupational exposure.
E. Source Person Serological Evaluation: Obtain source information relevant to exposure
   1. Test for Hepatitis B surface antigen (HBsAg), Hepatitis C virus (HCV) antibody
   2. Test for HIV antibody after obtaining informed consent
   3. If source unknown, assess for likelihood of presence of blood borne viral infection
F. Hepatitis B Evaluation/Prophylaxis Following Significant/Percutaneous Exposure
   Exposed person serological evaluation:
   1. Baseline: HBsAg, HBV DNA, HBeAg, HBeAb, ALT, HBcAb-IgM, and HBsAb. Recheck each every 4 weeks to track the serologic course of infection.
   2. Follow-up: HBsAg, HBs antibody / ALT / AST at 3 and 6 months
   3. Prophylaxis (see chart)
G. Hepatitis C Evaluation / Prophylaxis Following Significant / Percutaneous Exposure
   1. Baseline: anti-HCV, ALT / AST
   2. Follow-up: anti-HCV, ALT/AST at 3 and 6 months
   3. Prophylaxis: None recommended
H. HIV Evaluation / Prophylaxis Following Significant / Percutaneous Exposure
   1. Perform a baseline HIV antibody test.
   2. Test for other infections transmitted through occupational exposure, particularly hepatitis B (HBV surface antigen, surface antibody, core antibody), and hepatitis C (HCV antibody).
   3. Obtain complete blood count (CBC), creatinine and estimated glomerular filtration rate (GFR), and hepatic transaminases at baseline, before treatment with ARV medications.
   4. For women who may be pregnant, perform a pregnancy test.

(The institution should perform appropriate testing of the source patient testing for blood borne pathogens [e.g., HIV, HBV, and HCV] if the patient’s status is unknown.)
I. Tetanus Prophylaxis – TD – 0.5 mg if greater than 10 years since last immunization
Tetanus Immune Globulin (TIG) if indicated

J. Recommended for Post Exposure Hepatitis B Prophylaxis Treatment when source is found to be:

<table>
<thead>
<tr>
<th>EXPOSED PERSON STATUS</th>
<th>HBsAg Positive</th>
<th>HBsAg Negative</th>
<th>Unknown or untested</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. UNVACCINATED</td>
<td>HBIG x 1 plus</td>
<td>HBV vaccine series</td>
<td>HBV vaccine series</td>
</tr>
<tr>
<td></td>
<td>HBV vaccine series</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. PREVIOUSLY VACCINATED</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Known Responder</td>
<td>Test exposed person for HBs antibody:</td>
<td>No treatment</td>
<td>No treatment</td>
</tr>
<tr>
<td></td>
<td>1. If adequate, no treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. If inadequate, HBV vaccine</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Booster</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Known Nonresponder</td>
<td>HBIG x 2 HBIG x 1 plus HBV vaccine x 1</td>
<td>No treatment</td>
<td>If known high risk may treat as if source were HBsAg positive</td>
</tr>
<tr>
<td>3. Response Unknown</td>
<td>Test exposed person for anti-HBsAg:</td>
<td>No treatment</td>
<td>Test exposed person for anti-HBsAg:</td>
</tr>
<tr>
<td></td>
<td>1. If adequate no treatment</td>
<td></td>
<td>1. If adequate, no treatment</td>
</tr>
<tr>
<td></td>
<td>2. If inadequate, HBIG x 1 plus</td>
<td></td>
<td>2. If inadequate Hepatitis B vaccine booster</td>
</tr>
<tr>
<td></td>
<td>3. HBV vaccine booster dose</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

K. Provisional Public Health Service Recommendations for Chemoprophylaxis after Occupational Exposure to HIV by type of Exposure and Source Material

38
### Recommended HIV Post exposure Prophylaxis after Percutaneous Injuries

<table>
<thead>
<tr>
<th>Infection Status of Source*</th>
<th>Exposure Type</th>
<th>HIV Negative</th>
<th>HIV Positive (Class 1)</th>
<th>HIV Positive (Class 2)</th>
<th>Unknown HIV Status</th>
<th>Unknown Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Less Severe (e.g., solid needle, superficial injury)</strong></td>
<td></td>
<td>No PEP warranted</td>
<td>Recommend basic 2-drug PEP</td>
<td>Recommend expanded ≥3-drug PEP</td>
<td>Generally, no PEP warranted; however, consider basic 2-drug PEP for source with HIV risk factors§</td>
<td>Generally, no PEP warranted; however, consider basic 2-drug PEP if exposure to HIV-infected persons is likely§</td>
</tr>
<tr>
<td><strong>More Severe (e.g., large-bore hollow needle, deep puncture, visible blood on device, needle used in patient’s artery or vein)</strong></td>
<td></td>
<td>No PEP warranted</td>
<td>Recommend expanded ≥3-drug PEP</td>
<td>Recommend expanded ≥3-drug PEP</td>
<td>Generally, no PEP warranted; however, consider basic 2-drug PEP for source with HIV risk factors§</td>
<td>Generally, no PEP warranted; however, consider basic 2-drug PEP if exposure to HIV-infected persons is likely§</td>
</tr>
</tbody>
</table>

### Recommended HIV Post exposure Prophylaxis after Mucous Membrane Exposures and Nonintact Skin Exposures*

<table>
<thead>
<tr>
<th>Infection Status of Source*</th>
<th>Exposure Type</th>
<th>HIV Negative</th>
<th>HIV Positive (Class 1)</th>
<th>HIV Positive (Class 2)</th>
<th>Unknown HIV Status</th>
<th>Unknown Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Small Volume (e.g., a few drops)</strong></td>
<td></td>
<td>No PEP warranted</td>
<td>Consider basic 2-drug PEP§</td>
<td>Recommend basic 2-drug PEP</td>
<td>Generally, no PEP warranted**</td>
<td>Generally, no PEP warranted</td>
</tr>
<tr>
<td><strong>Large Volume (e.g., a major blood splash)</strong></td>
<td></td>
<td>No PEP warranted</td>
<td>Recommend basic 2-drug PEP</td>
<td>Recommend expanded ≥3-drug PEP</td>
<td>Generally, no PEP warranted; however, consider basic 2-drug PEP for source with HIV risk factors**§</td>
<td>Generally, no PEP warranted; however, consider basic 2-drug PEP if exposure to HIV-infected persons is likely§</td>
</tr>
</tbody>
</table>

### Options for Occupational Post exposure Prophylaxis of HIV Infection

* Unboosted atazanavir cannot be coadministered with tenofovir (use atazanavir + ritonavir).

Adapted from U.S. Department of Health and Human Services.

*Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Post exposure Prophylaxis.*
Basic Regimens with Two Nonnucleoside Reverse Transcriptase Inhibitors

**Preferred**
- Tenofovir 300 mg once daily + emtricitabine 200 mg once daily (available as Truvada, 1 tablet once daily)
- Zidovudine 300 mg BID + lamivudine 150 mg BID (available as Combivir, 1 tablet BID)

**Expanded Regimens (one of the following may be added to a basic regimen)**

**Protease Inhibitors**

**Preferred**
- Lopinavir/ritonavir (Kaletra) 400/100 mg BID

**Alternative**
- Atazanavir 300 mg once daily + ritonavir 100 mg once daily
- Darunavir 800 mg once daily + ritonavir 100 mg once daily
- Atazanavir 400 mg once daily*

**Integrase Inhibitors**

**Alternative**
- Raltegravir 400 mg BID

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L. Definitions of Degree of Exposure

**Massive Exposure**
- a. Large volume injection of blood (>1ml)
- b. Parenteral exposure to materials containing high titer of virus

**Definite Parenteral Exposure**
- a. Intramuscular (IM/deep) injury with a blood/body fluid* -contaminated needle
- b. Injection of blood/body fluid*
- c. Laceration or similar wound produced by a visibly blood/body fluid* - contaminated instrument which causes bleeding
- d. Laceration or similar fresh wound inoculated with blood/body fluid*
- e. Any parenteral inoculation of HIV/HBV virus samples (usually research settings) not included in A
Possible Parenteral Exposure
   a. Subcutaneous (SQ/superficial) injury with blood/body fluid*-contaminated needle
   b. A wound produced by blood/body fluid* - contaminated instrument which does not cause visible bleeding
   c. Mucous membrane inoculation with non-infectious body fluid

Non-Parenteral Exposure
   a. Intact skin visibly contaminated with blood/body fluid

*BODY FLUIDS POTENTIALLY INFECTIOUS FOR HIV: Blood products, body fluids, inflammatory exudates, any other fluid or tissue contaminated with blood.

FOLLOW-UP PLAN

A. Dental school students, faculty, staff, or patient report to Metropolitan Nashville General Hospital Emergency Department
   1. Medical evaluation is conducted per protocol
   2. Lab work is obtained per routine method. A copy of all lab results will be sent to the Office of the Associate Dean of Clinics and a copy placed in the Reportable Event file
   3. Written information is provided regarding levels of exposure, risks, and after-care instructions. Written information about how to contact the Infectious Disease Coordinator for additional information and counseling is provided
   4. An appointment for follow-up is made with the Emergency Room for all exposed individuals within 5-7 days

B. The Infectious Disease Coordinator
   1. If initial appointment is not kept, it is recorded in the patient record; the coordinator sends a letter and schedules an appointment for individual counseling with the coordinator as well as an appointment with the physician
   2. All positive baseline HIV’s will be re-appointed for further follow-up in the Infectious Disease Clinic per protocol or with private physician
   3. All patients whose baseline test results are negative will be counseled per Infectious Disease Clinic

*The School of Dentistry will be responsible for all expenses incurred for the source patient, faculty, staff, and students.
BARRIER TECHNIQUES
USE OF PERSONAL PROTECTIVE EQUIPMENT

Requirement 2  “All DHCP’s having patient contact will wear the following personal protective equipment (PPE) while providing patient care:

a. disposable gloves (gloves will not be washed for reuse with another patient and gloves must be removed when leaving the patient operatory);
b. surgical face masks;
c. eye wear with side shields;
d. outer gown to be worn over appropriate street clothing, the gown is not to be worn away from the direct patient treatment areas and is to be used only in the prescribed treatment areas.

Procedure/
Rationale  All procedures and manipulations of potentially infective materials should be performed carefully to minimize the formation of droplets, spatters and aerosols. Use of rubber dam, where appropriate, high speed evacuation, and proper patient positioning should facilitate this process.

Gloves & Hand
Washing  For protection of personnel and patients, gloves must always be worn when touching blood, saliva, or mucous membranes. Gloves must be worn by DHCP’s when touching blood-soiled items, body fluids, or secretions, as well as surfaces contaminated with them. Gloves must be worn when manipulating oral structures. Hands must be washed and gloved before performing procedures on subsequent patients. Repeated use of a single pair of gloves is not acceptable since such is likely to produce defects in the glove material which will diminish its value as an effective barrier. Gloves will be restricted to the cubicle while providing care. Gloves should not be worn to other clinical areas.

Face Masks  Face (surgical) masks must be worn when splashing or spattering of blood or other body fluids is likely, as is common in dentistry. Face masks will be restricted to the patient treatment areas (see below).

Protective Eyewear  The purpose of wearing protective eyewear with appropriate side shields is to protect the eyes from airborne bacteria, particulates and debris. Safety or prescription glasses with side shields or a face shield must be worn when performing all oral procedures or lab work. Eyewear should be cleaned and/or disinfected according to manufacturers’ recommendations between patients.

Clinic Jackets  Clinic jackets must be worn over street clothes when treating or examining patients. Clinic jackets should be changed at least daily or when visibly soiled with blood. Clinic jackets should not be worn outside the patient treatment area. Clinic jackets will be restricted to the patient treatment areas.
Patient Treatment Areas

Patient treatment areas will consist of the following:

A. Prosthodontic Clinic
B. Oral Diagnosis Clinic
C. Operative Clinic
D. Specialty Clinic (Pedo, Ortho and Perio)
E. Oral Surgery Clinic
F. General Practice Residency Clinic

Clinic Dress Restrictions

Clinic dress will not be worn in any other area for any reason. The school will furnish and laundry the clinic jacket for all faculty, staff and students.

CENTRAL STERILIZATION

Requirement 3

“All hand pieces, contra angles, hand piece accessories, burs and other instrumentation used for direct patient care will be sterilized after each patient. **Sterile packages will be opened in full view of the patient and after the patient has been seated for treatment.**”

Rationale

Objectives of the central sterilization room (CSR): to provide a method of sterilization of instruments which will prevent cross contamination to patients, faculty, students and staff.

Information for Utilization of CSR

The Central Sterilization area is located on the fourth floor in the Junior-Senior laboratory area, the southeast of the building.

1. This is designated for all clinical students for the purpose of sterilizing all clinical armamentarium.
2. The sterilization area is operated by two individuals. The schedule follows:

Schedule: Monday, Tuesday, Wednesday, Thursday & Friday 7:20 am – 5:30 pm

3. All students must carefully rinse all instruments before placing them in the cassette. Hand pieces should be packaged separately in pouches. Burs, clamps, hand cutting instruments, etc. will rust without special treatment. These instruments should be coated with emulsion prior to autoclaving.
4. The Central Sterilization center will wash instruments in the ultrasonic, wrap and autoclave them after they have been rinsed (and coated with emulsion when necessary).
<table>
<thead>
<tr>
<th>Average # of Daily Loads</th>
<th>Time Load Goes In</th>
<th>Time Load Comes Out</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7:45 am</td>
<td>8:30 am</td>
</tr>
<tr>
<td>2</td>
<td>12:00 pm</td>
<td>1:00 pm</td>
</tr>
<tr>
<td>3</td>
<td>4:30 pm (last load of the day)</td>
<td>8:00 am</td>
</tr>
<tr>
<td></td>
<td>After 4:30</td>
<td>8:30 am Instruments will be available</td>
</tr>
</tbody>
</table>

Using the Central Sterilization area insures the use of proper sterilization techniques and procedures for all dental instruments used by students. Thereby, the health of the patient, students, faculty and staff is ensured.

**REGULATED WASTE**  
**Requirement 4**  
**Definition**  
“Regulated Waste means liquid or semi-liquid blood or OTHER POTENTIALLY INFECTIOUS MATERIALS; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or other potentially infectious materials and capable of releasing these materials during handling; contaminated sharps; and pathological microbiological wastes containing blood or other potentially infectious materials.”

**Definition:** Other Potentially Infectious Materials  
Other Potentially Infectious Materials has been defined to specifically include saliva in dental procedures. The definition states “the following human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, SALVIA IN DENTAL PROEDURES, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids.”
**Sharps**

Sharp items (needles, empty anesthetic carpules, scalpel blades, and other sharp instruments) should be considered as potentially infective and must be handled with extraordinary care to prevent unintentional injuries.

Disposable syringes and needles, scalpel blades, and other sharp items must be placed into the puncture-resistant containers located in the area in which they are used. To prevent needle stick injuries, disposable needles should not be purposefully bent or broken, removed from disposable syringes, or otherwise manipulated by hand after use.

**Disposal of Sharps**

When the content of the Sharps container reaches the fill line, cap the container and place it in the red biohazard bin. Campus operations will pick up your red biohazard bin for disposal.

**Other Regulated (Medically infectious) Waste**

“All other (non-sharps) regulated (medically-infectious) waste will be disposed by placing the waste in the patient’s used head rest cover and then into an appropriate biohazard container.”

All cotton products, saliva ejectors, aspirators, treatment gloves, etc. used in patient care are considered “regulated waste” and should be disposed of by placing these products in the patient’s used head rest cover. The head rest cover should then be taken to nearest container that receives “regulated waste”.

All other waste should be disposed of in the cubicle trash container. This waste would consist of pare towels used to dry your hands, bags used to sterilize instruments, and other items not used in patient care.

**CUBICLE PREPARATION AND PATIENT TREATMENT**

**Requirement 5**

Cubicle treatment components will be cleaned, disinfected and ready for treatment using the following procedures:

a. clean and disinfect the cubicle treatment components with provided disinfectant
b. place all barrier wraps
c. **flush all water lines** (All waterlines should be flushed for three minutes at the start of each day and then flushed for 30 seconds between patients)
d. carts, tackle boxes and other containers of dental instruments will not be allowed in treatment cubicles
**Procedure**

Clean and disinfect the unit with an EPA registered, ADA approved tuberculocidal disinfectant capable of killing both lipophilic and hydrophilic viruses at use-dilution. This is provided for you in each clinic dispensary.

The environment of the dental clinic must always be clean and neat. This includes all personal items such as your patient treatment cart(s) and other storage treatment boxes. Initial and subsequent visual impressions made by your patients will influence the acceptance and value on the care you provide. Judge not only your own environment, but that of your peers. Ask yourself, “Would you want to be treated by your peer in their cubicle with their dental equipment?”

Additionally, the concept of the treatment area (e.g. cubicle, treatment carts, etc.), as an extension of your personal life or professional life, may not be an appropriate part of your practice. For example, stand back and look at your cubicle; what do you see? Study models should not be visible. Your personal pictures and posters may not create the professional impression that needs to be conveyed. Remember, you are a health care provider.

Any surface within 3 feet of the patient’s mouth must be considered contaminated after providing treatment that produces spatter. Therefore, cabinet doors and drawers must be closed during treatment. However, only surfaces that are touched must be cleaned and disinfected or have disposable covers changed between patients.

**Hand Washing**

Wash hands and wrists at the unit and glove.

Hands must always be washed between patient treatments contacts (following removal of gloves), after touching inanimate objects likely to be contaminated by blood or saliva from other patients, and before leaving the operatory.

The rationale for hand-washing after gloves have been worn is that gloves become perforated, knowingly or unknowingly, during use and allow bacteria to enter beneath the glove material and multiply rapidly. Extraordinary care must be used to avoid hand injuries during procedures.

However, when gloves are torn, cut or punctured, they must be removed immediately, hands thoroughly washed, and regloving accomplished before completion of the dental procedure. **DHCP’s who have exudative lesions or weeping dermatitis should refrain from all direct patient care and from handling dental patient care equipment until the condition resolves.**

Hand washing is mandatory (1) before treatment, (2) between patients, (3) after glove removal, (4) during treatment if an object is touched that might
be contaminated by another patient’s blood or saliva, and (5) before leaving the operatory.

**Hand Washing Technique**

The following is the recommended procedure for hand washing for routine dental procedures in the clinic and for routine laboratory work with contaminated items:

a. If necessary, remove visible debris from hands and arms with appropriate cleaner/solvent. Do not abrade skin by using a brush or sharp instrument
b. wet hands and wrists under cool running water
c. dispense sufficient soap or antimicrobial hand wash to cover hands and wrists
d. rub the hand wash gently on all areas, with particular emphasis on areas around nails and between fingers, for 15 seconds minimum before rinsing under cool water
e. Repeat steps c and d, and then dry thoroughly with paper towel.

Hand washing is an extremely effective procedure for the prevention of many infections that are acquired from the transmission of organisms on the hands. Cool water prevents cornstarch from penetrating the skin pores and minimizes the shedding of microorganisms from the subsurface layers of the skin. “Residual” antiseptic hand wash has a long lasting antimicrobial effect on the skin that improves with more frequent use throughout the day. (Journal of the American Dental Assoc., Vol. 55, No. 9, p. 624)

**Medical History**

Always obtain a thorough medical history. Include specific questions about medications, current illnesses, hepatitis, recurrent illnesses, unintentional weight loss, lymphadenopathy, oral soft tissue lesions, or other infections. Medical consultation may be indicated when a history of active infection or systemic disease is elicited.

**Protective Eyewear**

Protective glasses must be worn when treating patients. **Patient, faculty, staff, and students** are required to wear protective lenses under the following conditions:

a. while using hand instruments
b. while operating rotary cutting instruments
c. while operating lathes, torches, autoclaves, and other types of equipment
d. while using or manipulating any material (liquid or solid)
e. during any other activity that could be construed as a potential danger to the eyes
f. since the use of protective eyewear is required by state law, any patient refusing to wear them will NOT be treated in the clinic
**Barrier Wraps**
Surfaces that will be contaminated, but not cleaned and disinfected between patients should be covered with barrier wrap. Some examples would include: light handles, light switch, air/water syringe control, etc.

**Patient Records**
Do not touch the patient record with contaminated gloves. If an entry has to be made in the patient record during treatment, an appropriate barrier must be used on the pen and over the portion of the record that the contaminated glove touches (a paper towel and/or piece of overhead acetate may be used for this purpose).

**Use of Rubber Dam**
A rubber dam will be used whenever possible in tooth preparation. The rubber dam is an excellent barrier against the spread of infectious materials caused by spatter.

**Use of High Speed Evacuation**
High-speed evacuation should be used whenever possible when using the high-speed hand piece, water spray, ultrasonic scalar or during a procedure that causes spatter.

**Reduce Splatter**
The three-way syringe is another source of cross-contamination because it produces spatter. Therefore, caution must be used when spraying teeth and the oral cavity. When used, a potential for splatter must always be considered and appropriate precautions taken. The use on non-splatter producing methods, such as use of warm moist cotton pellets or use of water before air, is recommended.

**Dropped Instruments**
An instrument that is dropped will not be picked up and reused. If the instrument is essential for the procedure, a sterilized replacement must be obtained.

**Cleanup After Patient Treatment**
**Requirement 6**
1. Clean and disinfect all instruments
2. Decontaminate all surfaces by removing infectious wastes and then disinfecting all environmental surfaces
3. Rinse and disinfect all impressions, bite registrations, and appliances before they are sent to the laboratory

**General Environmental Surface/Equipment Cleaning and Disinfection**
Any surface that becomes visibly contaminated with blood or saliva must be cleaned immediately and disinfected using provided disinfectant. These products are usually applied, carefully wiped off with a disposable wipe, reapplied, and left moist for the recommended time interval. Blood and saliva should be thoroughly and carefully cleaned from instruments and materials that have been used in the mouth.
Many blood and saliva-borne disease-causing microorganisms, such as HBV and Mycobacterium tuberculosis, can remain viable for many hours (even days) when transferred from an infected person to environmental surfaces within dental operatories and other clinical areas. Since subsequent contact with these contaminated surfaces can expose others to such microbes and may result in disease transmission, adequate measures must be used in each clinical area to control possible transmission from contaminated surfaces.

**Use of Barriers**

A practical and effective method for routinely managing operatory surface contamination between patients is to use disposable blood/saliva impermeable barriers, such as plastic film and aluminum foil, to shield surfaces from direct and indirect exposure. Removal of blood, saliva and microbes is accomplished by routinely changing surface covers between patients. Time-consuming cleaning and disinfection procedures between patients can be minimized.

**Cleaning Between Patients**

Thorough cleaning between patients is necessary for those uncovered operatory surfaces that are routinely touched and become contaminated during patient treatment. The following guidelines will be followed:

**Acceptable Disinfectants**

Only those chemical disinfectants that are EPA-registered, ADA approved hospital-level mycobactericidal agents capable of killing both lipophilic and hydrophilic virus at use dilution are considered acceptable agents for environmental surface disinfection. Use of any chemical killing-agent not so approved is unacceptable.

**Cleaning Protocol**

The following protocol for disinfecting the dental delivery unit between patients will be used:

1. remove gloves and wash hands immediately
2. complete entries on all forms and records relating to the treatment provided and dismiss the patient
3. Put on utility gloves before the clean-up

**Disinfect Impressions, etc.**

Bite registrations, impressions, models, dies and prostheses become contaminated. These items must be cleaned and disinfected prior to removal from clinical areas. Impressions made with materials containing an approved antimicrobial agent and poured with a gypsum product also containing an approved antimicrobial agent shall be rinsed with water, shaken dry and bagged in a headrest cover for transport to the laboratory.

**Clean Eyewear**

Rinse and clean eyeglasses (or face shield) with detergent and water. Set aside to dry

**Prepare Cubicle**

Prepare for the next patient or prepare cubicle for days end. The following items should be disinfected:

a. Dental unit
b. Air/water syringe
c. Light handles and switch
d. Saliva ejector holder
e. Patient chair
f. Operator or doctor stool
g. Paper product container
h. Don’t disinfect or use alcohol on the light shield as it will pit and discolor

Requirement 7 Personal Hygiene

All DHCP’s will follow basic personal hygiene procedures;

a. Hair cleared away from the face
b. Facial hair covered by a face mask
c. Fingernails should be clean and short

USE OF EXTRACTED TEETH

Requirement 8

Extracted teeth used in education should be considered infective and classified as clinical specimens. Extracted teeth should be cleaned and disinfected.

Procedures/Rationale

Extracted teeth used in education should be considered infective and classified as clinical specimens because they contain blood. All persons who collect, transport, or manipulate extracted teeth should handle them with the same precautions as a specimen for biopsy.

Universal Precautions

Universal precautions should be adhered to whenever extracted teeth are handled; because preclinical educational exercises simulate clinical experiences, students enrolled in dental educational programs should adhere to universal precautions in both preclinical and clinical settings. In addition, all people who handle extracted teeth in dental educational settings should receive hepatitis B vaccine.

Cleaning & Storage

Before extracted teeth are manipulated in dental educational exercises, the teeth should be cleaned of adherent patient material by scrubbing with detergent and water or by using an ultrasonic cleaner. Teeth should then be stored, immersed in a fresh solution of sodium hypochlorite (household bleach diluted 1:10 with tap water) or any liquid chemical germicide suitable for clinical specimen fixation. A biohazard label should be affixed to the certain storage container.

Use of PPE

Persons handling extracted teeth should wear gloves. Gloves should be disposed of properly and hands washed after completion of work activities. Additional personal protective equipment (e.g. face shield or surgical mask and protective eyewear) should be worn if mucous membrane contact with debris or spatter is anticipated when the specimen is handled, cleaned or
manipulated. Work surfaces and equipment should be cleaned and decontaminated with an appropriate liquid chemical germicide after completion or work activities. Extracted teeth may be given to the patient after removal.

Failure to Comply

Requirement 9 Failure to comply with the above Basic Requirements will result in appropriate disciplinary action.

The Associate Dean for Clinical Affairs and/or designee will have frequent announced and unannounced visits to all clinical areas to monitor infractions of infection control.


SMOKING

SMOKING IS NOT PERMITTED IN THE SCHOOL OF DENTISTRY

i. POLICIES AND PROCEDURES ON DENTAL MERCURY HYGIENE

Mercury vaporizes easily as room temperature and can be taken into the body from the air while breathing. Mercury can also be taken into the body by direct contact with the skin. Mercury has a strong affinity for nerve tissue. Extensive mercury exposure may manifest itself with an abnormal increase in nervous irritability. Some of the other symptoms may include loss of appetite, depression, insomnia, losing of teeth, copper-like taste, and pigmentation of the marginal gingiva, nausea, and diarrhea and kidney failure. Most of these effects occur rarely in dental personnel. However, faculty, staff and students must be careful about protecting themselves from unnecessary mercury exposure. In order to provide this protection, the following recommendations should be observed in order to reduce the risk of mercury contaminations.

1. All personnel involved in the handling of mercury, especially during training or indoctrination periods, will be alerted to the potential hazard of mercury vapor and the necessity for observing good mercury-hygiene practices.

2. All clinics where mercury is used will be well ventilated since the prime source of mercury exposure is atmospheric.

3. The clinics should be monitored for mercury vapor at least once annually. Urinalysis for mercury should be performed annually on all students, faculty and staff who regularly use mercury.

4. Utilize encapsulated alloy/mercury and be certain that the amalgamator arms completely enclose and support the capsule during trituration.

5. Retrieve all amalgam scraps and place them in the container located at the service
opening of the Operative dispensary and the Prosthodontics dispensary.

6. Do not carpet dental operatories. Continuous seamless sheet flooring carried up the walls for at least 10 cm is preferred.

7. Mercury is to be stored in unbreakable, tightly sealed containers away from any source of heat.

8. Use a no-touch technique for handling amalgam. To alleviate the necessity of squeezing the amalgam mass to express excess mercury, use a low mercury-alloy ratio, preferably 1:1. If the amalgam or mercury, or both, must be handled, non-porous gloves should be worn. Also, exposed skin should be cleansed frequently. Any disposable materials contaminated with mercury or amalgam should be placed in a polyethylene bag and sealed before disposal.

9. Clean up any spilled mercury immediately. Droplets may be picked up with narrow-bone tubing connected (via a wash-bottle trap) to the low-volume aspirator of the dental unit. Strips of adhesive tape also may be useful to clean up small spills. Droplets that cannot be reached can be dusted with sulfur powder. Remember that this is only a film coating of the mercury and will be effective only while the mercury droplets remain undisturbed.

10. Use water spray and high volume evacuation when removing old or finishing new dental amalgam restorations. Use a face mask to avoid breathing amalgam dust.

LOCAL ANESTHESIA

A. Use of Aspiration Syringes
   In the administration of local anesthetic agents, ONLY aspirating type syringes will be used in all clinical areas.

B. Needles
   1. In the administration of anesthetic agents, the diameter of the needle should not be less than 27 gauges.
   2. Hypodermic needles and syringes needles must be returned to dispensary personnel, by the students, for proper disposal.
   3. Anesthetic carpules (cartridges) are stored dry. Wipe the rubber cap with an alcohol sponge before use. Carpules may be immersed in tinted 70% isopropyl alcohol in a clean, wide mouth, covered container. The container should be labeled with the name and percentage of solution. (Carpules with any color change should be discarded).

Basic Life Support (CPR) Policy and Procedures

Consistent with the standards of dental care and the mission of the Meharry Medical College School of Dentistry (SOD) to deliver the highest quality care, faculty, staff, graduate and undergraduate students providing direct patient care must maintain Basic Life Support certification.
Evidence of successful course completion is presented to the Director of Compliance and Safety of Clinical Affairs. SOD employees who are not providing or participating in sedation dentistry are required to recertify biennially, (every two years). SOD employees who are providing or participating in sedation dentistry are required to recertify annually according to the Tennessee Dental Board of Examiners standards.

**HIPAA Policy:**

All faculty, staff, and students are required to complete annual HIPAA training. Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), individuals have the right to access, inspect, and obtain a copy of their Protected Health Information (PHI). The MMC SOD health care providers are committed to allowing individuals to exercise their rights under HIPAA and other applicable federal and state laws and will take necessary steps to address individual requests to access, inspect, and/or obtain a copy of their health information in a timely and professional manner.

**Eye-wear/Eye Protection Policy**

The School of Dentistry considers the safety of its patients to be of paramount importance. Eye protection is an essential component of our safety program. Therefore, patients are required to wear protective eyewear during any treatment that might involve use of sharp instruments or result in flying debris. The treating faculty, staff or student will provide this eyewear to the patient when necessary. Patients who prefer to wear their own glasses should be discouraged from doing so, since their glasses will not have side shields. Eyewear must be disinfected after each use.

**Amalgam Waste Policy and Procedure**

Amalgams containing materials as well as the amalgam capsules are to be placed in a wide mouth container with a screw top lid and labeled. The MMC Environmental Health & Safety Department is charged with the oversight of the amalgam waste recycling procedures and is responsible for the safe and efficient removal of the waste from the facility.

**Dental Unit Waterline Cleaning Policy**

**Purpose:** This policy provides infection control recommendations that should be followed to eliminate pathogens that may be present and multiply in dental unit waterlines.

- Sterile irrigating solutions shall be used for all surgical procedures that involve the cutting of bone
- When replacing dental units and devices, select products that can economically and reliably maintain water quality
- Cleaning dental unit waterlines shall be done on a bi-weekly basis, using an approved FDA (Food and Drug Administration) product to clean the lines
- For quality assurance purposes, the date of cleaning the waterlines will be recorded in a log book and maintained in each department
- Dental unit waterline sampling will be done on a quarterly basis and reported to the Infection Control Committee. The Department Chair and/or appropriate clinical staff will be notified of any water line showing contamination (greater than 500 cfu/ml).
Latex Allergy Policy

Identifying patients at risk should be a specific and integral part of the medical history, both initial and update.

- Obtain latex-free materials from the Dental Storeroom for each appointment
- Prior to any contact with the patient, change cover gown and wash hands to remove all glove powder residue from previous patient
- Dental procedures should be scheduled first case of the morning. Latex allergen levels in the room should be lower and morning appointments allow time for the latex dust from the previous day to be removed overnight
- Encourage latex-allergic, latex-sensitive patients to obtain and carry with them at all times some type of allergy identification such as a medical alert bracelet
- If a patient demonstrates symptoms of latex allergy, immediately stop procedure and notify the Dental School Emergency Team. Remove all potentially problematic items from contact with the patient

POLICY REGARDING THE USE OF IONIZING RADIATION General Guidelines

- Radiographic images shall be prescribed by faculty members and/or graduate students holding the D.D.S./D.M.D. degree and who are licensed to practice dentistry within the MMC School of Dentistry.
- Radiographic images shall be ordered only after an appropriate clinical examination and patient interview have been completed in order to establish the necessity for radiographic images and to determine which radiographic examination will most effectively contribute to an accurate diagnosis.
- The frequency and type of radiographic images that are taken to aid in routine maintenance of a patient’s dental health varies and the decision shall be made based on individual patient needs.

Culturally and Linguistically Appropriate Services Policy

Policy:
As part of Title VI of the Civil Rights Act of 1964 (the federal law that protects individuals from discrimination on the basis of their race, color, or national origin in all programs that receive federal financial assistance) when required, faculty, staff or students, can obtain interpretive services to provide assistance to non-English speaking patients at no charge.
The College’s consultant is Open Communication International Interpreting and Translation Services (OCI)/Avaza.
On-site Interpreters
- The Electronic Health Record (EHR) should be flagged in the ‘Alert section’ the patient’s preferred language by the student providing treatment.
- The student providing treatment will notify the Patient Service Representative (PSR) Coordinator of patients who will need interpretive or translation services.
- The Patient Service Representative (PSR) Coordinator will complete the On-site Request form.
• The Patient Service Representative (PSR) Coordinator will email the completed form to the On-Site Department (onsite@avaza.co).
• The Patient Service Representative (PSR) Coordinator will telephone OCI/Avaza to confirm the form has been received at (615) 534-3409.

  • When required, faculty, staff, or students, can obtain an interpretive services to provide assistance to non-English-speaking patients and patients at no charge.
  • Students, faculty and staff are required to make note of the impaired patients’ language preferences in the record.
  • The use of friends and family members to interpret is strongly discouraged. Refusal of interpretation services must be documented and signed in the appropriate progress note.
  • Minors (children under the age of 18 years of age) are never permitted to interpret.

Swallowing Foreign Objects Policy

Protocol for incidents involving patients swallowing various foreign objects associated with dental treatment provision – rubber dam clamps, burs, crowns, implant parts and pieces of broken instruments:
  • The student dentist will immediately alert the faculty and the SOD emergency response team in OS.
  • The provider will stay with the patient, monitor vital signs, observe for acute respiratory distress, and make a preliminary diagnosis from the clinical signs and symptoms and the patient’s response to careful questioning.
  • IN THE EVENT OF AN EMERGENCY, CALL THE SCHOOL OF DENTISTRY EMERGENCY TEAM AND FOLLOW DENTAL SCHOOL EMERGENCY PROCEDURES.
  • Attending faculty or student will make a call from the School of Dentistry to Metro General Hospitals’ Radiology Department for the necessary radiographs.
  • Transportation to Hospital Radiology (x-ray) is the responsibility of the provider or attending DDS. Transportation for sedated (but not emergent) patients may pose special risks. Obtain a wheelchair and transport the patient to the hospital. NOTE: AN ADDITIONAL PERSON MUST ACCOMPANY THE PROVIDER WHEN TRANSPORTING THE PATIENT TO HOSPITAL RADIOLOGY.
  • One escort will stay with the patient in Radiology while the other escort registers the patient.
  • If there is any question as to whether the patient has passed the object within three days, it is the responsibility of the provider and SOD RN to arrange for a follow-up radiograph to be taken.
  • Complete an Incident Report and forward it within 48 hours to the Office of Clinical Affairs.
  • Make an entry in the patient’s record completely describing the occurrence.
  • If the patient refuses the radiograph, proper notation should be documented in the chart.

Tuberculosis Control Plan

• All students who obtain clinical experience at MMC SOD shall receive their required initial screening through Campus Health Services or another approved healthcare facility (e.g.,
health department or a primary care physician’s office). The annual screening for individuals who have had a positive TST will be conducted at Campus Health Services. Students with potential exposures will also be evaluated at Campus Health Services.

- All employees who work directly with patients or in patient care areas must meet the screening requirement; required annually.

**Consent and Refusal of Treatment Policy**

The patient has a right to participate in decisions about their dental treatment and to have any questions answered before making a decision. Any treatment received will meet appropriate standards of care. You may refuse treatment and expect to be informed of the possible consequences of your decision.

**Confidentiality Policy**

Discussions about patients care will be done with as much consideration for their privacy as possible. A copy of your treatment record will not be released without their written permission, except as required through an insurance contract or by law. They have the right to read their dental record and to have the information explained as necessary.

**Food and Drink Policy**

Food or drink is **NOT** allowed in the treatment areas of the clinic. The student doctor lounge is the appropriate place for refreshments

**Protocol for Continuous Quality Improvement**

The cycle for quality improvement is to monitor risk management, appraising the quality of care provided, assessing quality improvements and recommending corrective action within the Meharry Medical College School of Dentistry Standard of Care.

**Protocol for Clinical Scheduling**

The Clinical Schedule and the Academic Schedule should always reflect the same opening and closing dates for the SOD. All changes to the Clinical schedule must be approved by the Clinical Dean. **Anyone instructing PSR’s to block or add additional schedules will be in violation of this protocol.**

**AxiUm Training Protocol**

The responsibility of the SOD AxiUm software system will be shared by the OIT support department, the Office of Clinical Affairs and the Financial Dean. All AxiUm modification must be approved by Clinical Affairs and the Financial Dean of the SOD before they are submitted to technical support.

Periodic training sessions will be scheduled as all upgrades to the system arise. The trainer concept will apply with all upgrades. AxiUm super users have been identified to assist with immediate
resolution of support as well as training. To assure uniformity of the system access is limited for designated levels of performance. Any computers not working properly are to be reported to the help desk.

Physical Audit for Compliance

A monthly physical Audit of each clinic will be conducted by the Compliance and Safety Director. This report will be submitted to each department chair for corrections and to corporate compliance for review.

Inventory and Dispensary Protocol

Inventory control and ordering is handled by a designated person of each department. Orders should be inputted into the Henry Schein site by end of day on Friday. Orders will be reviewed on Monday and submitted for Tuesday delivery. Orders will be processed weekly. Inventory and dispensary fall under the auspices of the Office of Clinical Affairs.

Clinic Repairs Work Order Protocol

All work orders for the Henry Schein representative must be submitted to the Office of Clinical Affair by Monday for service on Tuesday. The completion of the request will be filed in the Office of Clinical Affairs for record. Anyone who identifies flood or other potential emergency is required to report that emergency to the Office of Clinical Affairs and/or Campus Operations immediately.

Protocol for Patient Services Representatives

PSR’s are to maintain coverage of the registration stations at all times. The PSR’s are scheduled from 7:30 am to 5:00 p.m. Lunch schedules will be staggered from 11:00 am – 1:00 pm daily to ensure availability for students and patients during clinical hours.
PROTOCOL FOR MANAGEMENT OF EMERGENCIES
**Purpose:**

The protocol for management of medical-dental emergencies provides guidance and specific steps to be followed by faculty, residents, students and staff in all emergency situations.

All caregivers involved in patient care shall be certified in **Basic Cardiac Life Support** (BCLS) and therefore possess the skills necessary to initiate emergency care. Students and faculty are responsible for managing emergencies until relieved by OMS team and/or emergency respondents.

**Emergency Protocol**

Medical emergencies in the dental office setting are an unavoidable occurrence. The purpose of this policy is to establish the responsibility for patient triage, treatment, disposition and documentation of the emergency incident in both treatment and non-treatment locations within the SOD.

**The initial team will consist of the Faculty Attendant, the Student Doctor and a staff member. The Student Doctor will notify the Faculty Attendant of the emergency and then the staff member. The Student Doctor and Faculty Attendant will provide assistance to the patient within their scope, while the staff member imitates the emergency protocol:**

Pick up RED PHONE which dials directly to the Oral & Maxillofacial Surgery Clinic and announce that there is an emergency.

State clearly the clinic, floor and chair number where the emergency exists to the person receiving the call in Oral & Maxillofacial Surgery. Have the person receiving the call restate the exact location of the emergency to the caller.

The staff person should proceed to the WEST stairwell of that floor to meet the OMS emergency team and direct the team personally to the site of the emergency.

Have available your clinic oxygen source.

The Lead OMS Team member will assess the emergency and determine if Notification of the emergency team at Nashville General Hospital at Meharry (341-4357), MMC Security #6666 or the Emergency Medical Service #9-911 should be activated. **ONLY the Emergency Team should activate 911.** The Student/Staff member should state clearly that the team will be met in the front circle of the school (Meharry Boulevard)

Then notify the **Office of the Dean at 327-6207** that an emergency **(Code Blue)** exist. The Deans office will instruct the PSR First Floor Coordinator at **(ext. 5887)** to initiate an overhead page of Code Blue. This will allow clear access to all emergency exists for the medical emergency team.
Management of Medical Emergencies Before or After SOD Clinic Hours (before 8:00 a.m. and after 5:00 p.m. weekdays, on weekends or holidays).

Employees and students in all instances are to initiate or participate in emergency care to the extent of their education and training.

The first faculty /health care provider at the emergency assumes responsibility for initial evaluation and appropriate action. When additional medical assistance is needed, Metro Nashville Emergency Medical Services (EMS) should be contacted by calling 911 as well as Campus Security 6666 with the exact location of the emergency.

Order of responsibility:
I. OMS Team – assumes responsibility for management of the emergency by providing advanced cardiac life support.
II. Faculty on floor or staff person – will provide a brief explanation of the perioperative events that lead to the emergency.
III. Student – will serve to record the event(s) and other information as instructed.

Designate someone to keep a record (usually initial student provider):
IV. Time of the emergency
V. How long it took the team to respond
VI. The time that any drugs, including oxygen, was administered
VII. The name and dosage of the drug
VIII. Vital signs

Assure optimum emergency care is provided

1. The time the service was activated should be noted and the response time of the EMS and/or E.R. emergency team should also be noted.
2. A health care provider is assigned to accompany the patient to the facility (hospital, E.R., etc.) where care is continued.
3. All information that has been recorded about the emergency will accompany the patient when the patient is transported to another facility. This information will be returned to become a permanent part of the clinic record.

Follow-up

1. A Reportable Event Form and Investigation Report will be filled out completely within one (1) hour after the emergency procedure is completed and submitted to the Office of Clinical Affairs for appropriate disposition.
2. There will be a follow-up as to the disposition of the patient, if the patient was transported to another facility (Nashville General Hospital or Emergency Room, etc.) by the Office of Clinical Affairs.
Protocol for Emergency Evacuation

When in doubt always report!!!

We are all responsible for the safety and wellbeing of everyone in the SOD. When you suspect an emergency situation please respond.

• For Smoke or Fire please close all doors to the area for confinement.
• Report the emergency by dialing Ext: 6666 (with location)
• Activate the alarm
• Life threatening emergencies (domestic, uncooperative patients or visitors) report by dialing Ext: 6666
• The Response Team will start the evaluation process

As soon as an alarm is sounded in any area of the dental school, stay calm and if instructed exit the building. The alarm maybe the fire alarm and/or an overhead page for evacuation. Examples of emergencies requiring evacuation include fire, tornado, life or bomb threats, and suspected gas leaks. An evacuation team has been identified to assist with the process. All personnel will move to lower floors/exits using the stairwells. DO NOT USE THE ELEVATORS. Patients and visitors should be walked down stairs, providing assistance if needed. The team may be identified by their emergency orange vest.

Assembly Points for School of Dentistry:

Occupants in the School of Dentistry are to exit the building via the nearest exit and assemble at one of the following designated assembly points and remain until instructed to disperse.

Outside Assembly Point: PARKING LOT O
Inside Safety Location: BASEMENT
Inside Information Point: FRONT LOBBY OF SOD

Occupants must proceed to the designated areas to ensure emergency response personnel and vehicles have clear and immediate access to the site.

Significant Exposure

1. Stick with needle contaminated with blood or body fluid.
2. Puncture wound with a sharp or other instrument that has been contaminated with blood or body fluid.
3. Splashed or sprayed with blood or body fluid that contaminates the eyes, mouth, or other mucosal surface.
4. Incidents that result in cutaneous exposures involving large amounts of blood or prolonged contact with blood, especially when the exposed skin has an open wound, is chapped, abraised, or afflicted with dermatitis.
PROCESS

Wound care/first aid: Irrigate wound with normal saline or sterile water, Flush mucous membrane with water or saline, injuries requiring suturing or other intervention should be treated as usual.

A Reportable Event Form should be obtained from the clinic dispensary and completed.

All dental school faculty, staff, students and patient report to the Student Health Center located in the Meharry Clinic Building 3rd Floor, Suite 331, and immediately following exposure. If incident occurs after clinic hours report to Metropolitan Nashville General Hospital Emergency Department. If patient has been dismissed, student should still report to Student Health. The patient should be contacted to inform them to report to Student Health or their medical provider for evaluation and test. At the emergency room report a blood and body fluid exposure.

Foreign Body – Upper Airway Obstruction

Severe or complete upper airway obstruction due to a foreign body i.e. crowns, burs, files, rapidly progresses to unconsciousness and cardiac arrest within minutes.

Presentation

- Distress
- Choking, coughing
- Stops breathing
- Cyanosis
- Loss of consciousness

Management

Partial obstruction

- Encourage patient to cough up or spit out. Initially do nothing else.
- If poor air entry, increasing high pitched stridor, increased respiratory distress, manage as for complete airway obstruction

Complete Obstruction

- Initiate Emergency Procedure Protocol. Victim cannot speak, breathe or cough.
- If patient is in the dental chair sit them up, turn patient on their side in chair. Support chest with one hand and deliver five sharp back blows between the shoulder blades with the heel of the other hand.
- If back blows fail, five abdominal thrusts (Heimlich).
Unconscious obstruction

- Commence CPR.
- Consider cricothyroidotomy if no air entry.

If foreign body is swallowed with no obstruction, the student should report it to the attending faculty, obtain an incident report and escort the patient to the Radiology Department located on the 1st floor of General Hospital.

**Emergency Eye Wash**

Eye wash stations are located in each clinic. All faculty, staff and students should be informed of the location of each station. Each station should have free access and be free from any debris restricting the locator sign.

If an accident to an eye occurs, move quickly to the eye wash station. Depress the lever to begin the flow of water. This lever may be on the side of the bowl or on the floor near the base of the stand so that it can be pressed with the foot. Do not remove the plastic caps covering the eye wash nozzles, as they will swing away once the flow of water starts. Lower your head into the basin until the jets of water come directly into contact with both eyes. Hold your eyes wide open using your thumbs and index finger. Keeping the head steady, move your eyes around by looking from side to side and up and down. This will help rinse as much of the eye as possible. Continue rinsing for at least 15 minutes or until a doctor arrives and is able to provide treatment. Even in cases of apparently minor injury, consult with the faculty attendant as soon as possible in care additional treatment or an examination is necessary.

**Syncope**

Patient feels light headed or dizzy, possibly nauseous, uncomfortable or agitated. They will appear pale and sweaty with a slow pulse and hypotension.

**Management**

Syncope in a fit, healthy young patient:

- Relieve any compression on the neck and maintain an airway.
- Raise patient’s legs.
- Give supplemental oxygen.
- When consciousness is regained, patient should be kept flat and reassured.
- Once pulse and blood pressure recover, slowly raise patient to seated position.
Patients with significant medical problems, or when syncope is prolonged or complicated by seizure activity, the patient should be transferred to General Hospital for further assessment.

**Medical Emergencies** such as anaphylaxis, asthma, seizure, hypoglycemia, cardiac emergencies and stroke may occur during dental treatment. The Emergency Procedure Protocol should be followed.

**RISK MANAGEMENT-REPORTABLE EVENTS**

A “Reportable Event” is any unusual event or circumstance” that is not consistent with normal routine operation of the College and its staff. It may be an error, poor outcome, or an accident that could have or has resulted in an injury. Events are not always with error or mistake, but could be a bad or unexpected result. A good rule of thumb relating to a Reportable Event, “When in doubt, fill it out!”

Examples:
- Slips/Falls
- Sharp instrument injuries, animal bites or scratches
- Exposure to toxic or other hazardous waste or substances

**INJURY AND ILLNESS REPORTING**

**Students:**
- Report all incidents immediately to the Office of Clinical Affairs
- Document all reportable incidents on the Reportable Event Form
- Report to the Student Health Center located on the 3rd Floor Room 331 of the Meharry Clinic Building with completed Reportable Event Form

**How to obtain a Reportable Event Form Online:**
- [www.mmc.edu](http://www.mmc.edu)
- Click on Meharris
  Under Heading Forms
- Click on Human Resources
  Under Human Resource Forms
- Click on Reportable Event Forms
- Office of Corporate Compliance
- Compliance Documents and Forms
- Reportable Event Form
Completing the Reportable Event Form:

- Complete main body of the form (Sections 1-6)

- State only the facts, clearly and concisely in the space provided for a description of occurrence (Section 3)

- When an injury is sustained, Section 7 of the form should be completely signed by the treating physicians

- Students must report incidents to the attending faculty. Students must report incidents to the Deans of Clinical Affairs of their respective schools. Visitors must call Security (Section 8a)

- Type or print the name of the name of the person completing the reportable event form (Section 9a)

- Signature of person completing the form, title, and date form was completed
STANDARDS OF CARE
I. General Standards

A. Patient Care Guidelines

1. No prospective patient will be denied admission to the clinics or provision of care on the basis of race, color, creed, religion, national origin, sex, age, marital status, disability, public assistance status, veteran status, or sexual orientation.

2. Each prospective patient will be offered the earliest available screening consultation appointment upon contacting the College. Patients will receive an initial oral examination during the screening consultation appointment.

3. Assignment of comprehensive care patients will occur within two weeks of the screening appointments when possible or, if the patients choose not to wait, they will be notified to consider seeking alternate care.

4. Patients may be accepted for treatment in the undergraduate or graduate clinical programs when the patients’ needs are within the scope of that program. Patients who are not accepted will be informed of this decision and the information will be documented appropriately.

5. Patients will receive considerate, respectful and confidential treatment consistent with state and federal guidelines.

6. Patients will be notified of personal responsibilities and all applicable College policies and procedures prior to the initiation of elective treatment. Each patient will receive a copy of Patient Rights and Responsibilities and have the opportunity to ask questions and be provided understandable answers. Each patient will receive a copy of the Notice of Privacy Practices and will be asked to sign the Acknowledgement of Receipt of the Notice of Privacy Practices in order to be a patient of the College. Patients will also be required to fill out the Patient Record of Disclosure form if they wish for information to be revealed to a particular person about their treatment.

7. Patients who are assigned will receive diagnostic and treatment services that are consistent with their medical histories along with any dental and/or medical consultations. These services may include oral pathology or stomatology consultations, appropriate premedication’s, proper timing of the procedures, postoperative medications, anesthesia and pain control, and a selection of alternative treatments. Appropriate behavior management techniques may be employed to manage significant anxiety and fear.

8. Patients (or their parent or legal guardian) seeking comprehensive care will have reasonable, informed participation in decisions concerning their dental health, be informed of reasonable treatment alternatives, benefits, risks, including the risk of no treatment, and prognosis in terms they can understand. Patients upon request may receive a copy of the treatment plan following appropriate consultations and faculty approval.

9. The frequency of treatment for each patient will be determined on an individual basis, depending upon the treatment plan selected and clinic availability. Active comprehensive care patients will be offered an appointment at least one time per month if possible until treatment is completed or other mutually agreeable arrangements have been made.
10. Patients will receive treatment in a sequence appropriate to meet their needs. 
11. Patient care will be under the supervision of faculty members.  
12. Patients will have access to complete and current information about their condition.  
13. Patients will receive treatment that meets the Standards of Care as outlined and corrective actions will be monitored by the faculty and the College’s Quality Assurance Program.  
14. Patients will be referred by faculty as appropriate to a predoctoral or graduate student, or an alternative clinician if the patient’s needs are beyond the skill of the predoctoral student, or for completion of treatment when a student has performed a procedure to the best of his or her ability but the service does not meet the College’s Standards of Care. Patients will be informed of fee adjustments as appropriate.  
15. Patients’ health histories will be updated at each visit and any changes annotated in the record.  
16. Treatment plans will be updated and modified to reflect the changing clinical conditions and needs, patient response to therapy, financial factors and patient availability.  
17. Upon completion of a comprehensive treatment plan, the patient will receive an exit examination, including: 
   a. Assessment of treatment to ensure the applicable standards of care has been met;  
   b. Assessment of the patient’s current oral health status;  
   c. Assessment of the patient record for compliance with record keeping standards;  
   d. Determination of the patient’s interest in, and appropriate interval for, a recall examination based on the patient’s individual needs and risk factors;  
   e. Determination of the patient’s commitment to continue care at the College or the indication for referral or discontinuation of care.  
18. Limited care services may be made available to appropriate patients to support the unique needs of the clinical teaching program. Such care may include but not limited to oral surgery, orthodontic, endodontic, restorative, preventive, and diagnostic services, as long as the service being sought is within the scope of the individual program and will improve the oral health status of the patient.  
19. Patients accepted for limited services that are within the scope of the clinical programs will be admitted for care when they consent to limited treatment, the limitation of care is clearly documented, and such limitations are not detrimental to the patient’s health and well-being.  
20. The College will provide a twenty-four hour dental emergency access for active patients of record, to an on-call advanced education student.  
21. Emergency dental care will be available during designated clinic hours for unassigned patients on a space available, fee-for-service basis.  
22. Comprehensive care and/or limited care patients will be notified in writing of any inactivation from care or of a severance of the professional relationship between the College and the patient.  
23. Faculty may elect not to accept patients for treatment who request care that is inappropriate relative to the College’s Standards of Care. Patients of record who are noncompliant or whose behavior poses a threat to a student, employee and/or the College
may be discontinued on the recommendation of the supervising faculty or program director.

24. Patients whose treatment is discontinued in accordance with the Patient Understanding and Informed Consent form will be informed in writing. The College will attempt to ensure that the patient’s dental status is stable, provide emergency service for a defined reasonable period of time and suggest that the patient seek an alternate dental provider for completion of treatment.

B. Examination Standards

1. Patients accepted for comprehensive care will receive a comprehensive clinical examination.
2. Patients will receive a complete extra oral head, neck and oral examination including periodontal and dental assessments to detect the presence of odontogenic and other orofacial pathosis. The assessment will include a thorough medical, dental and social history and assessment of risk factors for oral and regional disease.
3. Patients will receive additional appropriate diagnostic tests when such testing is indicated and justified by symptoms or findings of the comprehensive examination.
4. Patients with a history or clinical findings that suggest the need for medical, psychological or other professional consultation will be informed of the need for consultation in terms they can understand.

C. Radiographic Standards

1. The frequency and extent of each radiographic examination will be determined by the professional judgment of a faculty member, based on guidelines established by the Dental Patient Selection Criteria Panel (CDRH/FDA).
2. Radiographic examinations will be ordered and interpreted by a faculty member and documented in the electronic health record.
3. Patients will be protected with a leaded apron that includes a thyroid collar unless prohibited by the radiographic technique.
4. The exposure setting that provides images of acceptable diagnostic quality will be used. In the rare occasion when conventional film is used, the fastest film speed that provides radiographs of acceptable diagnostic quality will be used.
5. Exposure techniques will be established to assure that radiographic images are of diagnostic density.
6. Films will be processed with regard to time and temperature and under proper conditions of safe lighting.
7. Digital images will be acquired through the patient’s electronic health record to assure proper identification. The radiographic survey will be properly labeled to denote the type of images acquired prior to storage to the server. For radiographic film examinations, the films will be mounted, properly labeled with the date, record number and patient name, and scanned into the patient’s electronic health record.
8. Radiographic generating equipment in the College will be inspected on an annual basis by a certified radiation physicist to assure compliance with Tennessee Regulations for Control of Radiation.
D. **Patient Dental Records**

1. The electronic patient record will be established and maintained to document all diagnostic and therapeutic actions as well as significant communication related to patient care. The record will include the health history, treatment consultation reports, dental charts, and progress notes, correspondence related to care, laboratory reports, and prescription data for medication, radiation history and radiographs.
2. All non-active or inactive paper patient records will be stored at officially designated sites. Archiving and retention of the inactive patient paper dental record will follow the accepted policies of the state regulations.
3. Medical alert status will be indicated in the electronic patient record and described in the medical history tab. The medical alert indicates an increased risk of complications to dental care due to a medical condition that may require the alteration of routine dental treatment methods in order to maximize the safety of the anticipated treatment.
4. The contents of the patient record are confidential and managed in accordance with state and federal (i.e. HIPAA) laws. Access to the contents of the record will be on an individual right and need-to-know basis.
5. Information identified as confidential non-medical, such as financial information, is contained in a separate module of the electronic patient record.
6. The contents of the patient record will be made available to the patient or parent/legal guardian upon proper written request for a reasonable charge. The patient/responsible individual must sign the Release of Patient Record Information form.
7. A chronological narrative summary of each appointment will be recorded in the progress notes, including a description of procedures performed, alternatives to those procedures, pertinent risks, and notation that patient questions have been answered. Additionally, materials and products used, patient instruction, unusual occurrences or observations and significant remarks of the patient should be included.

E. **Medical Emergency Management**

1. Minor emergencies will be handled by the attending faculty where the emergency occurs.
2. For serious and potentially life-threatening medical emergencies during normal working hours, the College’s Advanced Life Support (Code Blue) Team will be activated by the emergency process while local basic life support measures (ABC’s) are being performed.
3. For after-hours medical emergencies, or when the Code Blue Team is not available, the Emergency Medical System (EMS) will be activated by calling #9-911 while local basic life support measures (ABC’s) are being performed.
4. Clinics will be stocked with appropriate and current resuscitation equipment and devices, including emergency oxygen with a bag-valve-mask system, emergency drug kits, and emergency eyewash stations.
5. Clinical faculty, staff, and students will be trained and maintain their CPR provider status.
6. Clinical faculty, staff, and students will review medical emergency procedures annually. Each medical emergency will be reported to the Associate Dean for Clinical Affairs and reviewed for compliance with College policy.
F. Infection and Biohazard Control
   1. Patients will receive care consistent with the policies and procedures in the College’s Exposure Control Plan and Protocol on Infection Control. Standard precautions for infection control will be utilized for all patient care.
   2. The medical gas delivery system will be inspected annually for proper function.
      Exposure levels of nitrous oxide will be monitored annually per NIOSH guidelines. Portable anesthesia units will be checked annually for proper calibration.
   3. Potentially hazardous chemicals will be labeled in accordance with NFPA 704 labels, stored utilized and dispensed of per applicable OSHA and EPA, Tennessee Commission of Environmental Equality (TCEQ), and Tennessee Department of State Health Services standards. Individuals who handle potentially hazardous materials will receive appropriate training in the risk, personal protection and emergency procedures applicable in the event of injury or exposure, and have access to Material Safety Data Sheets (MSDS) information upon request.
   4. Eyewash stations will be accessible in or near all clinical and laboratory areas where potentially hazardous materials may be handled.
   5. Fire safety inspections will be conducted annually.
   6. An on-going compliance assessment program will assure that the standards for infection and biohazard control are met and that mechanisms are in place to document corrective actions.

II. Clinical Standards: Predoctoral

A. Endodontic
   1. Diagnosis will be based upon patient history, clinical examination and the use of appropriate diagnostic aids.
   2. Endodontic treatment plans may include vital pulp treatment or root canal therapy.
   3. Treatment will be initiated when the restorability of the tooth has been established.
   4. Therapy will be undertaken under rubber dam isolation.
   5. The access preparation will conserve hard tissues and facilitate proper instrumentation.
   6. The canal preparation will conserve hard tissues and facilitate proper obturation.
   7. The obturation will properly seal the root canal to prevent reinfection.
   8. A post-operative radiograph will be taken to confirm the quality of the obturation.
   9. A permanent restoration will be placed as soon as possible after obturation, preferably upon completion of the obturation.

B. Fixed Prosthodontics and Operative
   1. Diagnosis will be based upon patient history, clinical examination and the use of appropriate diagnostic aids.
   2. Treatment plans will be developed that provide reasonable function and esthetics and offer reasonable alternatives when appropriate.
   3. Active disease of the hard and/or soft tissues will be controlled prior to initiating definitive restorative care.
   4. Preparation design will follow accepted biomechanical principles.
5. Definitive restorations will replace the missing tooth structure so that the contours provide reasonable health of the surrounding hard and soft tissues, reasonable occlusion and esthetics.
6. Patients will receive instructions regarding the need for proper maintenance of the restoration and supporting tissues.

C. **Removable Prosthodontics**
   1. Diagnosis will be based upon patient history, clinical examination and the use of appropriate diagnostic aids.
   2. Treatment plans will be developed that provide reasonable function and esthetics and offer reasonable alternatives when appropriate.
   3. The prosthesis will restore reasonable form, function and esthetics in light of possible psychological and anatomical limitations and student capabilities.
   4. Patients will receive instructions about proper maintenance of the prosthesis and surrounding tissues.

D. **Oral & Maxillofacial Surgery (Pre-doctorate and Post graduate)**
   1. Diagnosis will be based upon patient history, clinical examination, and the use of appropriate diagnostic aids.
   2. Emergency treatment will be performed, as indicated, to alleviate acute oral infection and/or pain.
   3. Preprosthetic hard and soft tissue surgery will be performed, as indicated, to improve form, function and esthetics of a final prosthesis.
   4. The surgical removal of hard and soft tissues will be performed for reasons that include, but are not limited to: removal of diseased, non-restorable, or nonfunctional teeth; management of acute odontogenic or periodontal infection; optimization of prosthetic rehabilitation; prevention or elimination of pathology; improvement of oral hygiene; facilitation of orthodontic or restorative care; control or elimination of chronic pain or infection; repair of traumatic injuries; and/or improvement of esthetic, cosmetic, or functional deficiencies.
   5. Patients will be provided with appropriate post-treatment instructions, medications, and further care, as indicated.
   6. Human tissues removed during surgical procedures will be examined for gross appearance and, if indicated, microscopic examination. The need for microscopic examination will be approved by faculty and resulting reports filed in the patient’s record.

E. **Orthodontics**
   1. Patients will be screened to determine the nature of their orthodontic problem, if and when treatment is indicated, and referred appropriately.
   2. Diagnosis will be based upon patient history, clinical examination and the use of appropriate diagnostic aids.
   3. Treatment will be directed toward the management of limited orthodontic procedures of a non-skeletal nature so as to facilitate the placement of prosthesis, or improve function and/or esthetics.
4. Patients will receive instructions about the proper maintenance of the appliance(s), oral hygiene techniques, and the necessity for their cooperation in carrying out orthodontic treatment.

F. Pediatric Dentistry

1. Diagnosis will be based upon patient history, clinical examination and radiographs appropriate for each individual’s caries pattern, spacing and developmental stage of the dentition.
2. Treatment plans will be developed to preserve the primary teeth for function and to facilitate normal facial growth and eruption of permanent teeth.
3. Treatment for young permanent teeth will be planned to provide reasonable function and esthetics.
4. Treatments will be accomplished with the appropriate use of local anesthetic and behavior management techniques.
5. Human tissues removed during surgical procedures will be examined for gross appearance and, if indicated, microscopic examination. The need for microscopic examination will be approved by faculty and resulting reports filed in the patient’s record.

G. Periodontics

1. Diagnosis will be based on the patient history, clinical examination and the use of appropriate diagnostic aids.
2. Individualized oral hygiene instructions will be provided for each patient.
3. Treatment will be directed at eliminating or controlling etiologic factors and creating an environment conducive to periodontal health and stable clinical attachment levels.
4. Periodontal therapy will be performed in a sequenced and timely manner as a part of the overall interdisciplinary treatment plan.
5. A recall program of periodontal maintenance therapy will be recommended for each patient.
6. Human tissues removed during surgical procedures will be examined for gross appearance and, if indicated, microscopic examination. The attending faculty will determine the need for microscopic examination and document these findings in the progress notes.

III. Clinical Standards: Advanced Education – Graduate

General Practice Residency

Definition: Ethical or legal duty of a professional /resident / student to exercise the level of care, diligence and skill prescribed in the code of practice of his or her profession in the same of similar circumstances.
To assure that all rotating students are performing clinical procedures (as assigned) to a competency level, they are supervised by a dental resident and/or GPR faculty member. Students on the General Practice Residency Clinic rotation gain experiences to include, but not limited to, comprehensive dental care, diagnosis, treatment planning and prognosis, operative procedures, periodontal and dental hygiene procedures, simple extractions, assisting with complex dental
procedures; dental emergencies and working with medically compromised patients. The rotating dental student also experiences four-handed dentistry. The rotating student is checked at defined steps in procedures. Credit for experiences is awarded to students for certain procedures per the pre doctoral Department Chairs.

The protocol of infection control and procedures are strictly adhered to in the General Practice Residency Clinic. It’s imperative that the medical history is reviewed and updated if necessary at EVERY dental appointment.
DEPARTMENT OF ORTHODONTICS
DEPARTMENT OF ORTHODONTICS
STANDARDS OF CARE

The goal of modern orthodontics can be summed up as the creation of the best possible occlusal relationships within the framework of acceptable facial esthetics and stability of the occlusal result. Orthodontic treatment may be provided in the form of preventive or interceptive therapy. Preventive orthodontic treatment prevents major malocclusions from occurring, and includes space maintainers. Interceptive orthodontic treatment includes procedures to lessen the severity or future effects of a malocclusion and eliminates its cause. Examples of this type of treatment are correction of anterior or posterior crossbites, regaining minor space loss, etc.

A. INTRODUCTION

The goal of the Department of Orthodontics is to prepare each student in identifying the various types of orthodontic malocclusions, in assessing patients as to the proper type of orthodontic care that is needed, and in determining whether or not this treatment should be provided by a general dentist or an orthodontist. Prior to completing one’s experiences in the Department of Orthodontics, each student must demonstrate that he/she has achieved the following Meharry Medical College Predoctoral Competencies: 1.1, 1.2, 1.3, 2.4, 2.5, 2.6, 2.7, 2.8, 2.9, 3.1, 4.1.3, 10.1, 10.2, 10.3, 10.4, 10.6, 10.7, 10.8, 10.9, 13.1, 13.2, 13.3, & 14.1.

B. DEPARTMENT OBJECTIVES

1. To ensure that each student has experience in diagnosis and treatment planning of orthodontic malocclusions.
2. To help the student understand the integration of orthodontic treatment in the delivery of comprehensive dental health.
3. To emphasize the team approach to Comprehensive Patient Care.

C. DEPARTMENTAL POLICY AND PROCEDURES

1. Each student will prepare and present an appropriate number of orthodontic diagnosis and treatment plans until he/she has demonstrated competency in case presentations and knowledge of the various types of orthodontic malocclusions.
2. Each student is encouraged to participate in the treatment of at least one orthodontic patient before he/she graduates.
3. Active cases fall in the category of cases that would ordinarily be treated in a general dentist’s office.
4. Clinic forms can be obtained in the Department of Orthodontics. Services rendered to the patient will be recorded in the treatment notes and on the department’s form by the student rendering the service.

5. It is permissible for multiple students to work on one (1) active orthodontic case since active cases are sometimes difficult to find. All students assigned to the patient are held responsible for keeping up with the patient’s progress and knowing the diagnosis and treatment plan. When multiple students are assigned to a patient, all students must be present in the clinic when the patient is seen.

6. Initial and final records must be made for all active cases. These records consist of models, photographs and a panoramic radiograph.

Examples of Orthodontic Active Cases include the following:

1. Maxillary Hawley with an anterior bite plane
2. Correction of buccal or lingual crossbite of one tooth with bands and crossbite elastics
3. Habit breaking appliance therapy for thumb, finger, or tongue
4. Treatment of anterior spacing with a removable appliance
5. Treatment of mild crowding with a removable appliance
6. Treatment of posterior crossbites with removable or fixed appliance
7. Mixed dentition analysis along with a space maintenance appliance

D. SCHEDULING OF PATIENT APPOINTMENTS

1. All patients must be scheduled in the Dental Appointments Office before they can be seen in the orthodontic clinic
2. Once an instructor has been assigned to a given case, the students should try and schedule his/her patient’s appointment to coincide with the clinic schedule of the assigned instructor.
3. All active orthodontic patients should receive regular monthly appointments (e.g. scheduled every 4-6 weeks)

E. ORTHODONTIC DIAGNOSIS AND TREATMENT PLAN

The orthodontic diagnosis and treatment plan can be done on a patient in the clinic or on a simulated patient (orthodontic models). The patient will come from the student’s pool of patients. The simulated patient will be provided by the Department of Orthodontics. Each student is responsible for completing a total of 4 orthodontic diagnosis and treatment plans prior to graduation, two of which must be done before the end of the Junior year. This clinical experience cannot be shared between multiple students but must be done individually. The orthodontic diagnosis and treatment form can be obtained in the Department of Orthodontics office.
When performing an orthodontic diagnosis and treatment plan, the following information must be included on the evaluation form whether for a clinical patient or a simulated patient:

1. Angle’s classification
2. The canine relationship (Class I, II, or III)
3. Description of the overbite, e.g., as edge to edge, ideal, moderate or deep
4. Whether or not an open bite is present
5. The amount of overjet
6. Whether or not a crossbite is present and if so the type of crossbite and the teeth which are involved.
7. Description of the maxillary arch length
8. Description of the mandibular arch length
9. Methods which be used in treating the malocclusion
10. Statement regarding whether the patient should be treated by a general dentist or referred to an orthodontist

F. STUDENT EVALUATION

Student grading will be a combination of the quality of work as well as quantity and level of difficulty. A calculated grade consisting of a RVU (relative value unit) as well as the treatment specific grade will be used determine the student’s final grade in the course. Grades will be given at the end of junior year and end of senior year. All RVU’s and treatment specific grades will be available in axiUm for the student to review.

The relative value unit is assigned to each dental procedure code according to the level of difficulty of the procedure:

4 = Very Difficult (e.g. Delivering orthodontic appliances, correction of minor malocclusion cementing bands, etc. (D8040))
3 = Difficult (e.g. Fabricating Ortho appliances (D8040), space maintainers etc.)
2 = Somewhat Difficult (e.g. Ortho diagnosis and treatment plan on a live patient (D0150.8))
1 = Minimally Difficult (e.g. Ortho diagnosis and treatment plan on a model)

The treatment specific grade assigned to each procedure is based on the universal clinical grading scale:

4.0 = A  (Excellent performance without faculty assistance)
3.5 = B+ (Good performance without faculty assistance)
3.0 = B  (Acceptable performance without faculty assistance)
2.5 = C+ (Acceptable performance requiring faculty assistance)
2.0 = C (Minimally acceptable requiring faculty assistance)
<2.0 = Major infractions or clinically unacceptable performance requiring correction by faculty

The student must obtain an overall passing grade (minimum 2.0 or C) in each of the procedure in order to be considered competent.

The department recognizes that not every student will be able to perform a case in each of the required categories. Therefore a student will be allowed to work on orthodontic models if no live patient experiences are available. The instructor in charge will designate the particular models to be evaluated day. The cases will be graded using the normal grading procedures.

Minimum Performance Expectation:
There is a minimal expectation that each student obtain 4 RVUs from the beginning of the junior year to the end of senior year.

Fall junior: 1 RVU  
Spring junior: 1 RVU  
Fall senior: 1 RVU  
Spring senior: 1 RVU

Students are strongly encouraged to complete at least active case.  
Additional RVUs:

a. Additional RVUs can be added to the case for exceptional performance by the student as it relates to independence, knowledge base or exceptional cases – patients needing extensive treatment or treatment outside of routine care.

b. A RVU of zero may be recorded for case neglect (i.e. unprepared for treatment, poor concept of procedures being performed, procedure performed in an incorrect manner, etc.) These situations may negatively impact your overall clinical performance evaluation.

Orthodontic Procedure Codes

D0150-8 Orthodontic examination  
D8660 Orthodontic records  
D8010 Limited Orthodontic Treatment for the Primary Dentition per Arch  
D8020 Limited Orthodontic Treatment for the Transitional Dentition per Arch  
D8030 Limited Orthodontic Treatment for the Adolescent Dentition per Arch  
D8040 Limited Orthodontic Treatment for the Adult Dentition per Arch
DEPARTMENT OF PEDIATRIC DENTISTRY
STANDARDS OF CARE

The clinical policies of the pediatric dentistry department are designed to provide high quality experiences in the management of psycho-oral-dental problems in children. The goal is for each student to obtain the basic knowledge and clinical experience necessary to initiate the steps of anticipatory guidance through examination, prevention, treatment and referral when necessary. This experience will ensure competency in providing pediatric dental services as well as an incentive to maintain an interest in continuing education and excellence in their personal and professional conduct. The accumulated knowledge gained through clinical and didactic experiences should provide success on the state and National Dental Board Examination.

A. INTRODUCTION

The Department of Pediatric Dentistry strives to establish and maintain the highest standards of care in its departmental clinical programs. The minimum standards for the diagnosis and treatment of infants, children and adolescents in the pediatric dentistry clinic are equivalent to those of the new general dentist in the United States. The student clinical requirements should be interpreted as a minimum number and serve as a guide to clinical pediatric dentistry. Students are encouraged to maximize their pediatric dentistry clinical experience by working beyond this minimum level. Prior to completing one’s experiences in the Department of Pediatric Dentistry each student must demonstrate that he/she has achieved the following Meharry Medical College Predoctoral competencies:

1.1, 1.2, 1.3, 2.1, 2.2, 2.3, 2.4, 2.5, 2.6, 2.7, 2.8, 2.9, 3.1, 4.1.1, 4.1.2, 4.1.3, 4.1.4, 4.1.5, 4.1.7, 5.1.1, 5.1.2, 5.1.3, 5.1.4, 5.1.5, 5.1.6, 5.1.7, 5.1.8, 6.1, 6.2, 6.3, 7.1, 7.2, 8.13, 8.14, 8.15, 8.16, 8.17, 8.18, 8.19, 8.20, 8.21, 8.22, 8.23, 9.1, 9.2, 10.1, 10.2, 10.3, 10.4, 10.6, 11.1, 11.2, 11.3, 13.1, 13.2, 13.3, and 14.1

B. DEPARTMENT OBJECTIVES:

1. To provide a level of clinical experience in the basic and fundamental dental procedures for children in various dentition stages as would be within the level of competence of the new general dentist.
2. To prepare students clinically and didactically for graduate study.
3. To provide a conceptual appreciation for Pediatric Dentistry as a specific discipline.
C. DEPARTMENTAL POLICIES AND PROCEDURES

To assure that all student work is at or above the minimally acceptable level, the following conditions apply for clinical activity within the department:

1. Only properly registered pediatric patients will be treated in the pediatric clinic. The age range for the pediatric clinic is birth to and including 18 years of age. Patients receiving treatment must be accompanied by parent/guardian. If an adult other then parent/guardian presents then a written consent from the parent/guardian should be available.

2. All procedures will be performed under the strict supervision of the pediatric dentistry faculty, each of which is a trained and appropriately credentialed specialist in pediatric dentistry or a generalist with significant experience in the treatment of children and adolescents.

3. Pediatric patients will be treated in the pediatric dentistry clinic (Colgate Bright Smiles, Bright Futures Clinic); pediatric patients can be referred to other specialty clinic areas and treated with approval from the clinic instructor.

4. All cases that are accepted for treatment in the pediatric clinic must be within the scope of the student ability. Cases that are deemed to be inappropriate for treatment by a student will be fully advised and will receive the most appropriate referral to insure proper treatment as necessary.

5. The methods utilized in the diagnosis and treatment of cases in the pediatric clinic will be limited to those methods that are evidence-based and in accordance with the American Academy of Pediatric Dentistry’s policies and guidelines.

6. All clinical procedures shall be performed, minimally, to an acceptable ("passing") level. If necessary, a supervising instructor will assist or perform the treatment necessary to insure this level of care.

7. In order to allow effective communication between the patient and clinician in the pediatric clinic, parents may be discouraged from entering the treatment operatory, however, the parent will retain the ability to be present or in close proximity to the treatment area if they request to do so.

8. A suitable mechanism for the management of dissatisfied patients or parents is in place. A patient or parent may seek redress for any perceived grievances through the instructor in charge, the Department Chairman, and/or the Associate Dean for Clinical Affairs.

9. Maximum appointment times should be limited to 3 hours. This time should be less for younger and/or anxious pediatric patients. No physical restraint or force is to be used by students to gain patient cooperation.

10. Unmanageable patients and repeated broken appointments should be reported to the department as soon as possible. All broken appointments should be noted in axiUrn and swiped by instructor as “pt cancelled” or “no show” code.
D. GUIDELINES FOR THE PEDIATRIC DENTISTRY CLINIC/ROTATION

1. Each student will be assigned to the pediatric dentistry department by the Department of Clinical Affairs at the beginning of the semester. Students are responsible for keeping up with the rotation schedule. Students are expected to check axiUm prior to showing up for rotation to ensure preparedness.

2. The student will report to the clinic at the appropriate time and day assigned for clinic activity. Absence from the clinic will be accepted only with an excuse from the Office of Clinical Affairs or the Office of Student Affairs. Failure to report as assigned or as appointed to see a patient will result in advanced penalty.

3. Parents who call the school for an examination, emergency, evaluation, or treatment appointment will be appointed to the student on rotation for that particular day. The patient will be assigned to that student as a new case if there in no other previously assigned student.

4. In the event pediatric rotation students are treating patients, walk-in (non-appointment) pediatric patients may be managed, if approved, by one of several ways listed below:
   a. Provided with an appointment within one week
   b. Transferred to another student who is available
   c. Temporarily given first appointment procedures by another student

5. The student is highly encouraged to recruit patients. Patients recruited by the student will belong to that particular student, therefore it is preferred that the student perform the exam on their recruited patients. A student does not have to wait until their rotation day to schedule patients. If the student has unscheduled clinic time they may schedule their patient through the PSR.

6. A patient may be transferred to another student providing the parent and an instructor are made aware of the transfer. The student should annotate the transfer in the record and the record will be signed by the present student, transfer student, and an instructor. All documentation of transfer should be noted in axiUm.
E. PEDIATRIC DENTISTRY- ORDER OF CLINICAL TREATMENT

Registration/Finance: Patient goes to the dental school registration area for student assignment and registration of patient. Ensure all necessary financial obligations are fulfilled. Ensure all forms completed:
   a. Application for Service; b. Consent Form; c. Patient chart which will include needed forms (i.e. medical history, dental history, etc.) d. Encounter forms

Operatory readiness:
Students should indicate full readiness for procedures by having a neat and completed bracket table and demonstrable knowledge of all procedures to be completed. All supplies and armamentarium on hand (chair side) should also be present. The student should assure the chair is operable (suction, light, adjustment buttons, air-water spray and hand-pieces). Prior to seating patient.

Clinic Assignment: Report to the department of pediatric dentistry clinic to the instructor in charge and get permission to seat the patient. Each procedure performed must be cleared by the instructor on the clinical floor. Failure to get permission to precede with a procedure will result in the dismissal from the clinic.

Medical History: Review with parent/guardian in a private area (HIPAA guidelines).

Comprehensive Initial Examination: Cursory clinical observation Determine:
   a. emergency (immediate) needs
   b. chief complaint
   c. behavior conditions
   d. radiographic needs (obtain signed requisition)
   e. unanticipated factors

Radiography (1st or 3rd floor): Prescribed after the pt is examined; depending on the necessity and cooperation of the pediatric patient. The prescription of radiographs will follow the guidelines set forth by the American Dental Association (www.ada.org)

Preventive and/or Emergency Services:
   a. prophylaxis
   b. topical fluoride
   c. anticipatory guidance – (oral hygiene instructions, diet, non-nutritive habits
   d. emergency treatment – (extraction, pulpotomy/pulpectomy, palliative)

Comprehensive Treatment Plan: Chart per detailed intraoral/extraoral examination. Treatment plan must be in the school computer before initiating treatment.

Consultations: With other departments as indicated for specific clinical issues

Restorative Treatment: Follow the established sequential treatment plan. Anesthesia must be approved from instructor. Treatment to be performed under rubber dam whenever possible. Treatment should be completed in quadrant per instruction for preceptor.

Appliance Therapy: (Orthodontics/Pediatric Dentistry)
   a. space maintenance
   b. habits
   c. orthodontics
d. impressions/study models - use orthodontics supervision and evaluation

IMPORTANT: Records are important legal documents that must be handled in accordance with strict patient privacy and HIPAA guidelines. Instructor and student(s) must sign all forms, daily attendance sheets, chart, and all requisitions, etc.

F. STUDENT EVALUATION

Student grading will be a combination of the quality of work as well as quantity and level of difficulty. A calculated grade consisting of a RVU (relative value unit) as well as the treatment specific grade will be used determine the student’s final grade in the course. Grades will be given at the end of junior year and end of senior year. All RVU’s and treatment specific grades will be available in axiUm for the student to review.

The relative value unit is assigned to each dental procedure code according to the level of difficulty of the procedure:

4 = Very Difficult – (e.g. Pulp therapy, Stainless Steel Crowns, Space maintainer, etc)
3= Difficult (e.g. Advanced restorative procedure: Multi-surface restorations (D2160) etc.)
2= Somewhat Difficult (e.g. Basic restorative procedures: Amalgams (D2140), composites, etc.)
1= Minimally Difficult (e.g. Preventative procedures: examinations (D0150, D0120), prophylaxis, fluoride, sealants, etc.)/ Screenings and extramural site rotations, case observations)

The treatment specific grade assigned to each procedure is based on the universal clinical grading scale:

4.0 = A (Excellent performance without faculty assistance)
3.5 = B+ (Good performance without faculty assistance)
3.0 = B (Acceptable performance without faculty assistance)
2.5 = C+ (Acceptable performance requiring faculty assistance)
2.0 = C (Minimally acceptable requiring faculty assistance)
<2.0 = Major infractions or clinically unacceptable performance requiring correction by faculty

The student must obtain an overall passing grade (minimum 2.0 or C) in each of the procedure in order to be considered competent.

The department recognizes that not every student will be able to perform a case in each of the required categories. Therefore a student will be allowed to work on a pediatric dental manikin exercises during their rotation session if no patient is available. The instructor in charge will designate the particular procedure to be performed each day. The procedure will be graded using the normal grading procedures.
Minimum Performance Expectation:
There is a minimal expectation that each student obtain 100 RVU’s from the beginning of the junior year to the end of senior year.

- Fall junior: 25 RVU’s
- Spring junior: 25 RVU’s
- Fall senior: 25 RVU’s
- Spring senior: 25 RVU’s

Students are strongly encouraged to complete at least one pediatric patient comprehensively.

Additional RVU’s:

a. Additional RVU’s can be added to the case for exceptional performance by the student as it relates to independence, knowledge base or patient behavior management.

b. RVU’s will be given for exemplary service during community activities (Healthy Halloween and Children’s Dental Health Month and other departmental scheduled activities).

c. Work completed on mission trips, in private offices etc. will be looked upon favorably but will not be assessed a value.

d. Exceptional cases – patients needing extensive treatment or treatment outside of routine care may lead to additional RVU’s.

e. Procedures performed on an emergency basis to patients will be assessed on a case by case basis depending on the level of service provided.

f. A RVU of zero may be recorded for case neglect (i.e. unprepared for treatment, poor concept of procedures being performed, procedure performed in an incorrect manner, treatment of the wrong tooth etc.) These situations may negatively impact your overall clinical performance evaluation.

The Pediatric Dentistry clinical experience represents only a minimal portion of the expectations of students. The requirement should serve as an outline and incentive for students to maximize the total experience of dentistry for children. Treatment should be provided on a comprehensive basis when treatment/appointment conditions allow. All indicated treatment should be completed, or the case properly transferred or terminated by the Chair of Pediatric Dentistry, before case completion credit can be awarded to the student.

G. JUNIOR FINAL CLINICAL COMPETENCY EXAM (FCCE)

In order for a junior student to be advanced to the senior year clinical level of the Pediatric Dentistry Department he/she must be able to pass the Junior FCCE. This exam may be performed on a simulation case provided by the department. It may consist of a practical manikin exercise followed by an oral exam or a case presentation of a patient of record. In addition at the conclusion of junior year students should attempt to have completed a minimum of 50 RVUs. If
there is a deficiency it should be brought to the attention of the Chairman of the Department in an effort to rectify before entering the senior year.

REMEDIATION
A student failing to obtain a **PASSING grade** will be offered a re-take the Junior FCCE. The day and time for re-administration of the Junior Competency Exam will be at a mutually acceptable time for student and instructor. The format will be contingent upon the level of competency demonstrated by the student. The student will not advance to the senior level until he/she has successfully passed the Junior Final Clinical Evaluation Examination.

H. **Seniors - Competency for Graduation - Final Clinical Competency Examination (FCCE)**

During the second semester of the senior year a student will be able to partake in the departmental FCCE. The dates of the exam will be announced by the department and graded.

The exam will consist of a series of case studies and will include but may not be limited to the identification of the primary, transitional and permanent dentition, prevention, patient medical assessment, identification of certain dental conditions, treatment planning, behavior management etc. The exam is geared towards common cases seen in a general dentist’s practice. This exam may be performed on a simulation case provided by the department.

REMEDIATION
A student failing to obtain a satisfactory on the Final Clinical Competency Examination will be allowed to retake the examination until a satisfactory grade of “C” or better is achieved. The time for re-administration of the FCCE will be at a mutually agreed time for the student and instructor. A student retaking the exam will only be allowed to get a maximum grade of “C” on the FCCE.
P. ORAL & MAXILLOFACIAL SURGERY CLINIC: COMPETENCIES AND OUTCOMES

COMPETENCIES:
Junior and Senior rotation through the Oral & Maxillofacial Surgery Clinic is designed to provide the student with a range of various OMFS clinical cases to give the student clinical experience in patient evaluation, assessment, differential diagnosis, informed consent, proper patient positioning for extractions and other minor oral surgical procedures. In addition, students will be evaluated as to their competency in case presentation, local anesthesia, nitrous oxide sedation, use of instrumentation, the operative procedure, post-operative instructions, appropriate prescription writing, as well as detailed SOAP NOTE chart completion. The student’s clinical experience will also involve assisting residents in OMFS and GPR in more complex patient evaluation and treatment. This clinical hands-on competency assessment will be graded as per the OMFS GUIDELINES FOR CLINICAL GRADING (Student Clinic Manual). Any deficiencies in the overall care of the patient by the student will be remediated immediately. This will also include the student’s self-assessment in their case presentation of the patient.
In addition to the hands-on part of the OMFS Clinic rotation, students will also be given an Oral Competency Evaluation during each semester (8am Clinic Huddle) when on rotation in the clinic. This will consist of small group sessions with a faculty member presenting a patient case based evaluation. Each student will be expected to share in the discussion enabling the student in analyzing and identifying patient problems as well as formulating a differential diagnosis and treatment plan. Students will be discussing all aspects of patient evaluation such as SOAP NOTES, medical and dental history, examination procedure of the patient both clinical and radiographic, formulating a differential diagnosis and treatment plan along with appropriate informed consent and details regarding treatment options and potential complications as indicated by evidence-based criteria.

OUTCOMES:
The objective in the OMFS clinic rotation will be to help students to become competent in patient assessment, diagnosis, asepsis, infection control, pain management, oral surgery procedures, emergencies, treatment outcome assessment, and life support to develop the students’ clinical skills.
The objective in the oral competency evaluation will be for the student to develop skills in informed consent, professionalism, critical thinking, diversity and communication skills, as well as applying their knowledge of behavioral science to the clinical setting as an enhancement of patient management. In addition, the student’s ability to diagnose, treatment plan, and coordinate sequential treatment will be enhanced. During post-operative visits the student will appraise treatment outcomes as well as analyze patient response to treatment. The student will differentiate between normal healing response and delayed or complicated healing, and then create case-based modifications in treatment.
Total Clinic Experiences in the OMFS Clinic will be counted following the point system described below. A minimum total of 100 points must be accumulated to be cleared for graduation. Exceeding 100 points will enhance the overall grade in the OMFS Clinic. Students will accumulate points for each procedure done, but must achieve certain minimums to be found competent in that particular area as designated by accreditation standards.
The point system for satisfactory junior and senior rotations is outlined below. The points only serve to ensure adequate experience in OMFS procedures. For evaluation of the quality of performance see section Q – Student Clinical Evaluation. Both quantity and quality (along with other criteria) are considered in the total clinic grade.

**Junior OMFS Rotation**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Points</th>
<th>Minimum Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Consultations</td>
<td>each 1</td>
<td>5</td>
</tr>
<tr>
<td>Extractions (Simple)</td>
<td>each 2</td>
<td>30</td>
</tr>
<tr>
<td>Extractions (Surgical)</td>
<td>each 3</td>
<td></td>
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<tr>
<td>Minor Oral Surgery Procedure</td>
<td>each 5</td>
<td>10</td>
</tr>
<tr>
<td>Nitrous Oxide/Oxygen Sedation</td>
<td>each 1</td>
<td>2</td>
</tr>
<tr>
<td>Junior Clinical Competency Evaluation (Junior CCE) (one procedure performed independently)</td>
<td></td>
<td>Total: 5</td>
</tr>
</tbody>
</table>

**Total Junior Rotation Points:** 52

**Senior OMFS Rotation**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Points</th>
<th>Minimum Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Consultations</td>
<td>each 1</td>
<td>5</td>
</tr>
<tr>
<td>Extractions (Simple)</td>
<td>each 2</td>
<td>30</td>
</tr>
<tr>
<td>Extractions (Surgical)</td>
<td>each 3</td>
<td></td>
</tr>
<tr>
<td>Minor Oral Surgery Procedure</td>
<td>each 5</td>
<td>10</td>
</tr>
<tr>
<td>Nitrous Oxide/Oxygen Sedation</td>
<td>each 1</td>
<td>3</td>
</tr>
</tbody>
</table>

**Total Senior Rotation Points:** 48

**Final Clinical Competency Evaluation (FCCE)**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nitrous Oxide/Oxygen Sedation Evaluation</td>
<td>5</td>
</tr>
<tr>
<td>Clinical Evaluation</td>
<td></td>
</tr>
<tr>
<td>(posterior extraction performed independently)</td>
<td>5</td>
</tr>
<tr>
<td>Oral Examination</td>
<td>5</td>
</tr>
</tbody>
</table>

**Total FCCE Points:** 15

**Clinical Experiences & Clinical Competency Evaluations (Junior and Senior Years)**

Total: 115 points

At the end of the senior year, the student is expected to be **competent** in local anesthesia and post-operative care of surgical complications; **competent** in routine exodontia and minor oral surgery procedures; **minimally competent** in the administration of Nitrous Oxide/Oxygen sedation.
sedation; and exposed to the full spectrum of oral and maxillofacial surgery procedures. The student must perform at a satisfactory level in all areas to accumulate points. Grades will be tabulated by the daily grade given in the clinical encounter forms of the Department, properly executed signed and graded by the instructor of the day. Students will not be excused from the rotation even if their total points add up to more than the total required for the year. The correctness of the totals will be assessed by the departmental faculty in charge of grades.

Q. STUDENT CLINICAL EVALUATION

The clinical qualification, including professional conduct, of the junior and senior students will be based on the following criteria:

Competencies:

a. Case Presentation – Self Evaluation
b. Position of Patient
c. Position of Operator
d. Local Anesthesia Technique
e. Selection of Armamentarium
f. Use of Armamentarium
g. Operative Procedure
h. Postoperative Instruction
i. Prescription Writing
j. Prescription Appropriateness
k. Chart Completion

Threshold Values are identified on the STUDENT CLINICAL EVALUATION SHEET, located in the Oral and Maxillofacial Surgery Clinic.

<table>
<thead>
<tr>
<th>Threshold Value</th>
<th>Points</th>
<th>Procedure</th>
<th>Extraction Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excellent</td>
<td>3</td>
<td>Molar</td>
<td>4</td>
</tr>
<tr>
<td>Passing</td>
<td>2</td>
<td>Premolar</td>
<td>3</td>
</tr>
<tr>
<td>Poor</td>
<td>1</td>
<td>Canine</td>
<td>2</td>
</tr>
<tr>
<td>Failure</td>
<td>0</td>
<td>Anterior</td>
<td>1</td>
</tr>
<tr>
<td>Hard/Soft Tissue Surgery</td>
<td>3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Grade Scale:

37 – 31 = A  
30 – 28 = B+ 
27 – 25 = B 
24 – 22 = C+ 
21 – 19 = C 
Below 19 = F

Junior Clinical Competency Evaluation (Junior CCE) will be given in the final semester of the junior year. This evaluation consists of one extraction or surgical procedure performed independently.
Final Clinical Competency Evaluation (FCCE) will be given in the final semester of the senior year. The examination will be comprised of three parts:

1. Clinical evaluation of an independent performance of a surgical procedure
2. An oral examination covering clinically oriented cases
3. Nitrous oxide/oxygen sedation evaluation

OMFS GUIDELINES FOR CLINICAL GRADING SYSTEM
Juniors and Seniors will be given Clinical grades based on the following criteria.

Criteria 1: Competency in the Oral & Maxillofacial Surgery Clinic in patient care will be evaluated based on the STUDENT CLINICAL EVALUATION SHEET. This Evaluation Sheet has eleven competencies that the student will be given a Threshold Value (Points) on each patient encounter. A Procedure point value will be added to this and a grade based on the total points for that patient. This sheet should be filled out for each patient that the student participates in their care. The grading system is explained on that document. The student will be responsible for filling in the diagnosis codes, procedure codes, and whether the student assisted, observed, or performed which procedures. The student should request faculty or resident help when needed.

Criteria 2: Clinic competency will also be evaluated with reference to points accumulated during the semester for the various procedures that students perform. The point values for the procedures are delineated in the Student Clinic Manual under point “P”. The greater the surgical experience, the more points that are accumulated and the more the final grade will be enhanced. As clinical experience increases so does the student’s competency to diagnose various disease entities and to present to the patient appropriate treatment options relative to risk / benefits as well as informed consent. No points are given for assisting or observing procedures even though these times can enhance the educational experience and clinical competency. During each student rotation through the Oral & Maxillofacial Surgery Clinic the student will gain experience in total patient care and receive remediating instructions for any deficiencies. At the end of the Spring rotation the student will take a Clinical Competency Evaluation (Junior CCE & Senior FCCE) that will assess the student’s competency in a progressive manner. Prior to graduation during the Spring semester the senior student will be expected to pass a Final Clinical Competency Exam (FCCE). This will include a Clinical Evaluation (Posterior extraction performed independently), a Nitrous Oxide/Oxygen Sedation Evaluation, and an Oral examination.

Criteria 3: An Oral Competency Evaluation will also be used in arriving at a grade for each semester. These Oral Competencies will be case-based presentations given in the pre-clinic Huddles (8am). Each student on OMFS Clinic rotation will be expected to be in the OMFS Clinic Conference Room by 8am and to have an active part in the discussion. The more the student is involved in these Oral Competency small group sessions the more their competency will be developed.

Grade Formulation: Total extraction/surgical experience plus total points plus average clinical grade (Student Clinical Evaluation Sheet) plus average oral competency evaluation equals final
grade. The more extractions/surgical experiences the higher the grade. The higher the average
grade on the Evaluation Sheet and the Oral Competency Evaluation the higher the grade. **IF**
STUDENTS FAIL TO ATTEND THE MORNING PRE-CLINICAL HUDDLE, THE
GRADE FOR THAT DAY’S ORAL COMPETENCY EVALUATION WILL BE A ZERO.
This will be averaged into the grading formulation.
DEPARTMENT OF PERIODONTICS
Department Office
Location: 3rd floor, adjacent to the Periodontics clinic
Phone number: 615.327.6300

Faculty and e-mail addresses
Additional faculty to be announced.

Ms. Machelle Thompson, RDH, mfthompson@mmc.edu

Introduction
Welcome to the Periodontics clinic. This manual should ease your entry into the clinic. This manual contains information about clinic operations, management of patients, and student and evaluation of clinical performance. Most of the information relating to patient care was covered more comprehensively in the Freshmen, sophomore, and junior periodontics courses and the Caranzza’s Clinical Periodontology textbook, Fundamentals of Periodontal instrumentation by Jill S. Nield- Gehrig and Misch Contemporary Implant Dentistry. The manual should be used as a guide for the Periodontics Clinical activities. This manual must accompany students in the periodontics clinic for reference.

Periodontal Exam, Treatment Plan and Case Presentation:
All dentate patients must receive a comprehensive periodontal examination and sequenced treatment plan that addresses the patient’s periodontal, restorative, endodontic and prosthetic problems. The exam and treatment-planning visit will usually occur in the Periodontics clinic but may occur in the other clinics. Consultations from other department faculty may be needed during the examination and treatment-planning phase. Control of dental bacterial plaque is the basis for successful treatment and prevention of periodontal disease and caries. The sequence of therapy that best supports this concept is control of acute and chronic bacterial infections, if any, and making sure that the student incorporates the treatment planning lecture given by Dr. Singh.

This sequence must be followed for all patients. Failure to follow this sequence will result in reduction of daily grade/assessment.
These concepts of treatment planning have been covered in the sophomore and junior periodontics courses, so please refer to the syllabi for these courses and the Carranza’s textbook for review.
THE SUPERVISING FACULTY MUST GIVE STUDENT THE PERMISSION TO START ANY PROCEDURE IN THE PERIODONTICS CLINIC.

Before seeking permission to start, please do the following:
1. Follow the infection control guidelines as outlined in the clinic manual.
2. Read the patient’s chart and know the medical and dental history before seating patient.
3. Seat the patient and review the medical and past dental treatment with the patient verbally, place X-rays on the view box, and/or pull up on the computer screen, and have the chart available.
4. Present the medical history and the details of what is planned for the clinic session to the instructor. Be prepared to answer questions about the patient and the treatment planned. Permission to start will be granted if the above is followed.

A partial list of the required patient information for treatment planning is outlined below.

THE PERIODONTAL EXAMINATION MUST INCLUDE:

1. CHIEF COMPLAINT AND HISTORY OF CHIEF COMPLAINT
2. MEDICAL HISTORY
3. DENTAL HISTORY (FREQUENCY OF DENTAL VISITS IN THE PAST),
4. HEAD AND NECK EXAM (SKIN, THYROID GLAND, LYMPH NODES, TONGUE, SALIVARY GLANDS, ETC.)
5. OCCLUSAL EVALUATION
6. PLAQUE SCORE
7. PERIODONTAL CHARTING (MISSING TEETH, POSITION OF GINGIVAL MARGIN AND MUCOGINGIVAL JUNCTION, TOOTH POSITION, POCKET DEPTH, MOBILITY, FURCATION INVASION, BLEEDING ON PROBING, ETC.)
8. RADIOGRAPHIC EVALUATION

The information from the periodontal examination is used to make a diagnosis, identify the etiology and prognosis and to formulate an ideal and/or alternate sequenced treatment plans. To do so, carefully consider the information gathered from the patient examination and determine the diagnosis, identify the etiologic factors, decide on the prognosis and formulate two alternative treatment plans. Write the treatment plan in pencil so changes can easily be made. The notations should be changed to ink after the treatment plan is presented to faculty for approval.

The Treatment Plan: The best treatment plan for the patient is the one that develops after discussing the various options with the patient. Discuss the findings of the exam and all the treatment options with the patient and assess the patients’ desires and priorities. The discussion should include an explanation of each plan, cost, and the pros and cons. The final step in the process is to call an instructor over and present the case.
THE STUDENT MUST PRESENT THE PATIENT’S CASE TO THE SUPERVISING FACULTY MEMBER BEFORE STARTING TREATMENT. The presentation must include all of the pertinent information collected during the patient examination, namely the diagnosis, etiology, prognosis and at least two sequenced treatment plans with patient’s priorities. A properly executed examination and treatment plan chart should be executed for each patient. Remember to prepare for the treatment plan presentation by carefully considering the information collected during the patient examination and make sure it is complete. Do this before attempting to present the patient’s case to faculty.

Case presentation (Please follow this sequence when presenting a case):
1. Demographic information (gender, age).
2. Chief complaint and history of chief complaint
3. Medical history
4. Dental history
5. Present periodontal findings
6. Present radiographic findings
7. What is the diagnosis?
8. What is the etiology?
9. What is the overall and individual tooth prognosis?
10. What are patient’s desires and concerns?
11. What are the two sequenced treatment approaches that would solve the patient’s problems? (Include periodontal, endodontic, operative dentistry and prosthetics)

After the case is presented, the instructor will examine the patient and review the treatment options. The final treatment plan is a discussion of the various treatment options with the patient and acceptance of a treatment plan by the patient. The approved treatment plan is recorded in the axiUm and approved by the instructor.

Periodontal Surgery
The need for periodontal surgery is assessed after initial therapy is complete and at the time of re-evaluation. If the patient is found to need periodontal surgery, the findings are discussed with the patient, along with a description of the surgical procedures, along with the number of surgeries, associated fees, and alternative therapies. If the patient gives informed consent, then the surgical procedure is scheduled with the patient and faculty member. Students should assist in at least one surgical procedure on an assigned patient in the junior or senior year.

To schedule a periodontal surgery:
1. Explain the procedure to the patient and what can be expected during surgery and postoperatively.
2. Its students’ responsibility to collect the medical history and request consults from other specialities and physicians and present it to the attending faculty and document it on axiUm.
3. Have the surgical sign-off sheet signed by the instructor who does the evaluation of initial therapy.
4. Make an appointment for surgery with the patient and the supervising faculty Students should
know the rationale for the surgical procedure and the expected outcome prior to the surgical appointment. On the day of surgery, have the patient arrive 20 minutes early.

On the day of surgery:
1. Assist with the preparation of the unit and surgical instruments
2. Seat the patient in the surgical suite after the unit is completely prepared
3. Present the Surgical Consent Form to the patient and review verbally
4. Have patient sign the Surgical Consent Form
5. Record the blood pressure and pulse
6. Assist the surgeon during the procedure
7. Assess the patient’s condition following at the end of the procedure
8. Give patient the Post-operative Instructions sheet and review verbally
9. Schedule the suture removal visit at the appropriate time
10. Escort the patient to the main entrance
11. Assist in the clean-up of the surgical area
12. Record notes in the axiUm and secure faculty approval

Chart entry should include:
1. date of procedure and the instructor
2. type and rationale for the procedure
3. amount of local anesthesia and the method of administration
4. description of the procedure
5. any meds or rinses prescribed
6. whether post-op instruction given (written and verbal)
7. the date suture removal is scheduled (usually 7—10 days after surgery) Plan on seeing the patient 7 — 10 days after the suture removal visit to check healing and 2 weeks after suture removal. The suture removal and the post-op check visits are usually 30—40 minutes in duration.

Surgical therapy essay:
A brief write-up of the surgical procedure is required of the student and must be submitted to the department secretary one week after the surgical assist. The write-up should include the type of surgery, the rationale, and description of the procedure from initial incision to suturing.

**Evaluation of Student Performance - Daily Clinical Feedback and Clinical Performance Evaluations**

Students’ acquisition of clinical competency will be evaluated. Advancement through the two clinical years will depend on satisfactory daily clinical performance and passing four clinical performance evaluations (clinical competencies).

Clinical competency-based evaluation focuses on the skills and abilities that the student develops through clinical experiences. The standard used to assess competence is the knowledge and skills needed for a graduate dentist to practice independently. The number of clinical experiences
needed to achieve competence varies for each student and continued experiences increase with the skill level. A student who does not pass a clinical competency must have more clinical experiences before the test is repeated.

There will be four clinical competency evaluations in clinical periodontics. The exams will evaluate the students’ ability to gather diagnostic information relating to the patient, develop a diagnosis of the patients periodontal condition, establish an etiology, a prognosis, develop a sequenced treatment plan and to perform treatment. The clinical competencies are: 1) performance of oral hygiene instructions to patients, 2) performance of maintenance examination and treatment, 3) performance of periodontal exam and treatment plan on a patient with early to moderate periodontitis, and 4) performance of scaling and root planing.

All patients must be treated comprehensively and all dentate patients must have a periodontal examination and treatment. Passing a competency does not free students of responsibilities to the assigned patients. Remember, competency requires basic skills and the student is expected to continue clinical experiences to attain a higher skill level. Therefore, clinical experiences must continue throughout the school year.

**Junior Periodontal Clinical Performance Evaluation:**
There are two junior competencies that must be completed in the junior year before advancing to the senior year in clinical periodontics.

**Competency #1:** oral hygiene competency will assess the students’ ability to give and demonstrate oral hygiene instructions according to the individual needs of the patient. This competency must be performed on a patient after the student has performed and completed prophylaxes on three individual patients in the student clinic.

**Competency #2:** maintenance recall competency will assess the students’ ability to perform a complete maintenance exam and treatment. In addition, the student must be able to assess the patients’ need for active therapy, if any, and to set the appropriate interval for the next maintenance appointment. The prerequisites for taking this competency are the successful completion of at least 3 adult patients requiring maintenance therapy and successful competency #1. Four quadrants are the minimum of scaling and root planing experiences students should have completed before attempting to take a competency assessment, though some flexibility might be extended by the faculty. Faculty will be available to assist students in setting the most appropriate time to attempt a competency assessment.

**Senior Periodontal Clinical Competencies:**
There are two senior competencies that must be completed in the senior year before graduation. The senior competencies can only be attempted when the junior competencies are successfully mastered.

**Competency #3:** periodontal examination competency will assess the students’ ability to perform a complete periodontal exam on an adult patient with at least early to moderate periodontitis. The prerequisites are successful completion of the junior competencies and successful completion of at least two periodontal examinations and treatment plans on patients with at least early to moderate periodontitis.
moderate periodontitis.

**Competency #4:** scaling and root planning competency will assess the students’ ability to perform one quadrant of scaling and root planning on an adult patient with early to moderate periodontitis. **The prerequisites** are successful completion of the junior competency and successful completion of at least 8 quadrants of scaling and root planning in patients with periodontitis. The patient selected for competency assessment #4 must meet the following criteria:

- have at least six teeth in contact in the quadrant, two of which are molars
- have at least 8 surfaces with subgingival calculus, 4 surfaces of which have >5 mm periodontal pockets

Students intending to take a Competency Assessment must inform the supervising faculty member and get approval for the suitability of the selected patient. The competencies are taken independent of assistance by faculty because the assessment evaluates the students’ ability to perform the procedures independently. The student must show evidence of having completed the prerequisite procedures before attempting a competency. If a student is unsuccessful after one attempt, the competency must be repeated until successful. The student must show evidence of having completed the prerequisites for each competency.

***The student evaluation system in the periodontics clinic is designed to reward high quality, comprehensive patient care, and good communication with patients, faculty and staff, and the achievement of superior competency in preventing, diagnosing and treating periodontal disease. Evaluation of students’ performance will be based on a combination of daily clinical assessment, completion of patient treatment, timely recall maintenance visits for assigned patients and four competency assessments. Students will be awarded grades for clinical-based course(s) based on the following criteria: adherence to infection control guidelines, preparation for the planned procedure, professionalism, and quality of performance of procedures. This does not exclude the successful passing of the four Clinical Competencies.***
**Student Periodontal Clinic Requirements**

Dental students must complete the following requirements:

- The student must accumulate a total of **at least 75 clinic points.**
- Need to complete **at least 15 quadrants of scaling and root planning**
- Students will receive the following points per procedure
  - 2.5 # of points awarded for a prophy
  - 2.5 # of points awarded for maintenance / recall
  - 2.5 # of points awarded per quadrant of SRP

Students must successfully complete the Periodontal Clinic Requirements before graduation.

**Periodontics Clinic**

**S. O. A. P. Note**

Example for Patient receiving a **Dental Prophylaxis**

**S** – Patient presents to Periodontics Clinic with a chief complaint “I want to get my teeth cleaned.” Past medical history is non-contributory. Past dental history: patient received last dental cleaning 1 year ago and states she brush and floss twice daily.

**O** – Vital signs: B/P: 116/72, Pulse: 64, Resp: 16
Medical and dental histories were reviewed no changes. Clinical examination revealed gingiva is pink and stippled, slight plaque, probing depths range 1-3mm generalized. Radiographs – bitewing x-rays revealed no signs of bone loss or decay.

**A** – Diagnosis: Gingivitis

**P** – Periodontal re-evaluation completed (plaque assessment and periodontal probing). An adult prophylaxis was completed and patient was given oral hygiene instruction (brushing and flossing demonstration). Patient given Colgate 360 toothbrush, Colgate Total toothpaste and Acclean floss (waxed bubble gum). Patient dismissed from clinic in no apparent distress. N.V. 6 month recall
Grading Policy in Periodontics (Clinic)

A student is expected to report to the perio clinic every time when a patient is scheduled for the perio treatment.

1. At the end of Junior year, a student should receive “P” (passing) grade.

2. Upon completion of the clinical requirements, a senior student can expect grade “A” grade, provided other expectations are met. These expectations can include but not limited to proper management of the patient, professionalism, quality of treatment rendered, proper documentations of treatments rendered, and overall improvement the student has showed.

3. Students who are close to finishing the quantitative clinical requirements (80% and above but less than 100%) should receive grade “B+” provided other expectations are met as mentioned above.

4. Students who have finished these clinical quantitative requirements between 60% to 80% should get grade “B”.

5. Students at 50% (or 50% to 60%) of the requirements will get grade “C”.

6. Students with less than 50% of the clinical requirements can expect to earn grade “I” or even worse “F” depending upon other factors that interplay in the final decision making.
Department of Dental Public Health

Department Office: 4th Floor – Room 547
Departmental Phone Number: (615) 327-6210

Faculty: Gregory A. Stoute, D.M.D., M.P.H., Chairperson and Associate Professor
Jacinta Leavell, Ph.D., M.S., Associate Professor
Machelle F. Thompson, R.D.H., M.S.P.H., Associate Professor

Meharry Medical College School of Dentistry has a long tradition and the mission of helping to improve the oral health of our community. Following this tradition, the Department of Dental Public Health has developed community partnerships; work on oral health disparities research, with the goal to remove the barriers to dental care. The Department of Dental Public Health provides clinical instruction that is community-oriented and patient centered. The clinical experience permeates throughout the four-year curriculum. Services in the community provide needed care and prevention while educating our students in community health.

The Department of Dental Public Health coordinates the school’s community-based activities and serves as liaison to our external partners. This educational program provides first and second year dental students with the opportunity to work in a variety of community-based dental health centers in the Nashville area. Dental students provide auxiliary services to the community health centers while gaining valuable experience in caring for the underserved population. The following community health centers participate:

- Matthew Walker Comprehensive Health Center
- Downtown Homeless Clinic
- Samaritan Ministries
- Interfaith Dental Clinic

External rotation

This program enables third and fourth year dental students to gain clinical training in a variety of settings outside the University. The externs provide direct patient care to underserved populations who might not otherwise have access to oral health care services. The goal of the external rotation is to increase the student’s sensitivity to the dental needs among populations residing in underserved communities. The following community health centers participate:

- Matthew Walker Comprehensive Health Center
- Downtown Homeless Clinic
- Samaritan Ministries
- Interfaith Dental Clinic
**Ethics and Professionalism**

Students must be able to apply the principles of ethical reasoning, ethical decision making and professional responsibility as they pertain to the academic environment, research, patient care, practice management, and programs to promote the oral health of individuals and communities.

**School of Dentistry Predoctoral Competencies**

The School of Dentistry seeks to graduate excellent oral health care professionals. Competency, the ability to demonstrate knowledge, skills and attitudes from training and experience is the foundation of exceptional professionals. Prior to graduation, each student will have acquired the knowledge, skills, and values necessary to successfully integrate theory, research and practice.

Competencies:

1. The new dentist must be able to apply ethical principles to professional practice.
2. The new dentist must be competent to promote oral health of individuals, families, and groups within the community.
3. The new dentist must be competent to assess and manage dental needs of children and physically and mentally disabled patients.
4. The new dentist must understand the basic principles that permit successful operation of a dental practice.
5. The new dentist must be able to acquire, analyze and synthesize information in a scientific, critical, and effective manner.
6. The new dentist must be able to communicate effectively, both orally and in writing with colleagues, patients or guardians and peers, and the public at large.
GENERAL PRACTICE RESIDENCY PROGRAM
INTRODUCTION

The GPR program is based on the concept that oral health is an integral and interactive part of total health. The GPR rotation will expand the scope and depth of the predoctoral students’ knowledge and skills which will enable them to provide comprehensive oral health services to diverse medical compromised population groups.

STANDARD OF CARE

Definition: Ethical or legal duty of a professional/resident/student to exercise the level of care, diligence and skill prescribed in the code of practice of his or her profession in the same of similar circumstances.

To assure that all rotating students are performing clinical procedures (as assigned) to a competency level, they are supervised by a dental resident and/or GPR faculty member. Students on the General Practice Residency Clinic rotation gain experiences to include, but not limited to, comprehensive dental care, diagnosis, treatment planning and prognosis, operative procedures, periodontal and dental hygiene procedures, simple extractions, assisting with complex dental procedures; dental emergencies and working with medically compromised patients. The rotating dental student also experiences four–handed dentistry. The rotating student is checked at defined steps in procedures. Credit for experiences is awarded to students for certain procedures per the predoctoral Department Chairs.

The protocol of infection control and procedures are strictly adhered to in the General Practice Residency Clinic.

It’s imperative that the medical history is reviewed and updated if necessary at EVERY dental appointment.

SENIOR/JUNIOR PROTOCOL FOR TREATING PATIENTS IN GPR

1. You will be assigned to a resident – The resident will guide and advise you of what steps you need to take to ensure the patient receives the care/treatment he/she needs.
2. Complete the Patient Summary Form – You MUST fill in the patient’s summary form for each patient seen. (See Forms). Fill in ALL the information required on the form, including the resident you are working with. This form will help when you write up your SOAP notes.
3. SOAP Notes - You will not receive credit for any procedures in GPR until your SOAP notes are written correctly. Please have the resident check your SOAP notes before you leave. To write and input your SOAP notes into axiUm, please follow the following steps:
   a. Ask the PSR personnel for access into axiUm for the patient you have seen.
b. Proceed to write the SOAP notes to include
   - Why and what the patient presented to the clinic for
   - ASA classification/vitals
   - Anesthetic dosage in mg. (See chart in clinic – we use 1.7 ml carpules)
   - Diagnosis and treatment planned/performed
   - Procedure(s) for next visit

4. **Medical history** must be fully completed in axiUm - even for an emergency visit.
5. **DO NOT ENTER PROCEDURE CODES** - The resident that you have been assigned to work with will enter the procedure codes.

---

**PATIENT SUMMARY NOTES**

1. Date: ______________
2. Resident: ______________
3. Patient’s Name: ________________________________
4. Appointment Type: (Please circle which one applies)
   a. Limited Exam
   b. Complete Exam
   c. Consult
   d. Preliminary Impressions
   e. Final Impressions
   f. Amalgam or Resin restorations – T# and Surfaces____________
   g. Crown Prep T#____________________
   h. Pulpectomy T#____________________
   i. Endo T#____________________
   j. Extraction T#____________________
   k. Other________________________________________________

6. Vitals: Blood Pressure_________________ Pulse_________________

7. Medical History:

8. Chief Complaint:

9. X-rays / Diagnostic tests:

10. Diagnosis:
11. Differential Diagnosis:

12. Treatment performed:

13. Prescriptions:

14. Next Visit:

15. Other Information:

Referrals

Patients are referred to the General Practice Residency Clinic from the pre doctoral program because of medical complications or clinical complex case. We require a referral form to be completed from the referring student dentist and faculty member. We see student dentists’ patients when school is closed on an EMERGENCY BASIS only. The fees for services in the GPR clinic are higher than those for the student clinic.
School of Dentistry
General Practice Residency Program
Referral Form

Referred from (Department): ________________________________
To: ________________________________

PATIENT INFORMATION:
Name: ________________________________ Birth date: __________
Address: ________________________________ City: ________________ State: _________
Telephone: ________________________________
Parents/Guardian: ________________________________ Contact Number: ________________

REASON FOR REFERRAL:
☐ TREATMENT (as requested):
*** (Please provide GPR Clinic with appropriate details of problems; i.e. urgency, areas of concern, tooth or teeth numbers).

☐ RELEVANT HISTORY:
### (Indicates any special factors – either dental and/or medical – such as known allergies, specific medical problems relevant to the diagnosis and/or treatment)

Please check the appropriate box(es) below as it relates to this case:

☐ Patient needs a consult appointment
☐ Radiographs are enclosed
☐ Notify on completion
☐ Please report – written
☐ Patient needs post-referral maintenance

Comments: ______________________________________________________________

Referring Faculty Name (PRINT): ________________________________ Department: ________________
Signature: ______________________________________________________________ Date: ________________

Student Doctor (PRINT): ________________________________ Classification: (circle one) D2  D3  D4
Signature: ______________________________________________________________ Date: ________________
DEPARTMENT OF ENDODONTICS
CODA Reference Standards:
   a) Diagnose and manage pulpal and periradicular diseases.
   
   b) Perform therapeutic procedures designed to preserve the vitality of the dental pulp.
   
   c) Perform non-surgical root canal treatment on uncomplicated single and multi-rooted teeth.
   
   d) Assess the success of failure of endodontic treatment by observing pre, and post treatment by observing and interpreting signs and symptoms of the degeneration or regenerations.
   
   e) Recognize the indication for surgical and complicated non-surgical root canal therapy.

SOD Competencies:

   a) Gather the necessary bio-mechanical, esthetic and social information to formulate a treatment plan.
   
   b) Perform extra oral and intraoral examinations for the prospective patient, including assessment of vital signs, and record those findings.
   
   c) Apply patient history, examination, diagnosis and prognosis for treatment planning Endodontic cases.
   
   d) Create and maintain treatment records.
   
   e) Identify patient’s chief complaint, expectations, and goals.
   
   f) Prescribe and perform a radiograph examination appropriate for the patient.
   
   g) Obtain informed consent for the delivery of mutually accepted treatment.
   
   h) Initiate an appropriate written medical consultation or referral to clarify a question related to the patient’s health.
DEPARTMENT OF ENDODONTICS

The accepted definition of Endodontics is “That branch of Dentistry concerned with the morphology, physiology, and pathology of the human dental pulp and periradicular tissues”. Its’ study and practice encompass the basic and clinical sciences including biology of the normal pulp, the etiology, diagnosis, prevention, and treatment of diseases and injuries of the pulp and associated periradicular tissues.

In addition to these knowledge areas, the graduating dentist must be able to critically evaluate his or her level of competency as a diagnostician and clinician. Based on this evaluation, the student must recognize the effect of his or her own limitations in managing patients with conditions for which he or she possesses less than a competency level of skill; these patients are referred first, to the General Residency Program (GPR) and if necessary from there to the appropriate specialist for consultation and/or treatment.

This section of the Clinic Manual contains a brief review of Departmental policies, techniques and procedural guidelines. All students should review the section, and be familiar with it before coming to the clinic.

Providing patient treatment for the first time, especially in a new clinical discipline is always an emotionally taxing endeavor. Although the stress associated with your first few endodontic experiences cannot be completely eliminated, it can be greatly reduced if you are familiar with the procedures you will be expected to follow and prepare yourself for the appointment.

Preparation for the appointment should at a minimum include, but not be limited to:

1. Review of Anesthetic techniques.
2. The importance of rubber dam placement and how to place it for root canal therapy.
3. Review the anatomy of the tooth you will be working on.
   a. Canal depth or size of chamber.
   b. How many canals, roots are normally found on this tooth.
   c. Technique for access opening, shape of the opening.
4. How am I going to clean and shape this tooth – **Step-by-Step**.
5. What will I place in the tooth between appointments? How will I temporize the tooth?
6. How am I going to obturate the tooth? – **Step-by-Step**.
7. How will the tooth be restored? All necessary clinical consultations for restorability of the tooth prior to starting a root canal procedure to include Periodontics and Prosthodontics.
8. An organized work area.
Departmental Goals:

THE STUDENT WILL BE ABLE TO COMPLETE THE FOLLOWING TASKS IN THEIR ENTIRETY:

1. Complete and understand the initial case assessment without error.
2. Make the proper pulpal and periapical diagnosis based on patient history and tests.
3. Arrange work area in a manner that efficiently shows the organization of armamentarium, and provide an aseptic endodontic treatment.
4. Isolate any tooth that requires endodontic treatment (which means no contamination from saliva).
5. Cut an access preparation which allows straight line access to the apical area.
6. Properly clean, shape and obturate canals with three dimensions fills.
7. Expose and process accurate radiographs, write up cases using standardized entries.
8. Complete necessary experiences, including recalls and case reviews, in the allotted time.

I. CLINICAL POLICIES AND PROCEDURES

A. Eligibility: Before you are allowed to schedule or treat patients in the endodontic clinic you must have successfully completed the sophomore core course, the manikin exercise, diagnostic competency exam, assist on at least one endodontic case to completion (instrumentation and obturation), and complete the endodontic case of a liked tooth chosen on a manikin preceding the appointment. Your first case must be on an anterior tooth.

B. Consultation: If you are in another clinic and need endodontic consultation, one of the Endodontic Clinic Faculty will provide the consultation. Needless to say, you will be required to perform all diagnostic tests prior to an instructor check.

C. Scheduling Patients: All endodontic patients are scheduled by the Patient Service Representative (PSR). If you are eligible to treat the patient, make an appointment with PSR. If your patient cancels, notify PSR immediately in order to free the chair. Endodontic chairs are limited and your classmates may need your canceled appointment time for their patient. YOU MAY ONLY HAVE ONE ACTIVE CASE SCHEDULED. In other words, you may not schedule a new patient until; you have completed the patient on the appointment book. Do not try to circumvent this policy; chairs for endodontic appointments are limited.

D. Operative Management: Cleanliness, neatness and organization all constitute a part of your clinical grade. The only instruments allowed in your operatory are those specially issued for Endodontics. NO OTHER INSTRUMENTS,
CONTAINERS, OR EXTRANEOUS GEAR SHOULD BE IN THE OPERATORY. Any instrument entering the pulp chamber or canals must be sterile! You are expected to leave the operatory in a clean and debris-free condition when you finish your treatment procedure. All gloves, rubber dam, and gauze must be placed in the red bio-hazard container. Any material that has come in contact with saliva, blood, or patient tissue should be discarded in the red bio-hazard container and should not be inadvertently left in the operatory areas! All sharp instruments are placed in the sharps container provided.

E. **Instruments:** The basic instruments and supplies for endodontic treatment are in your student kit. The tray set-up is illustrated in (figure 1), or provided by the Endodontic Department.

1. Equipment needed for endodontic procedures:
   a. High speed hand piece as well as selection of round burs, and safe-ended diamonds.
   b. Rubber dam equipment: selection of rubber dam clamps, rubber dam punch, and rubber dam frame.
   c. Hemostats, or endo-ray, scissors, spatula.
   d. Tip for air-water syringe

2. Additional equipment:
   a. Clinic gown
   b. Safety glasses (student and patient)

F. **Radiographs:** Radiographs are a permanent, legal part of the record, therefore, they must be of good quality, and with the tooth being treated centered on the sensor or film and properly developed. 3 mm of bone must be present in the periapical area. All radiographs will also be taken using the Digital Radiography system.

1. **Preoperative radiograph:**
   Often films must accompany insurance claim forms. If you have accepted a patient whose emergency treatment (i.e. Opening of tooth) was done by someone else, you must take your own pre-operative films. **THIS RADIOGRAPH WILL ALSO BE TAKEN WITH THE DIGITAL X-RAY SYSTEM.**

2. **Treatment radiograph:**
   The number of treatment films will vary with each case; do not hesitate to ask for advice from your instructor. Treatment film is taken with the rubber dam in place, using a hemostat or endo-ray for a film placement. If you are unsure of angulation, film placement etc., please ask for instructor
assistance. This will reduce the number of retakes and unnecessary patient radiation exposure.

3. **Postoperative Radiograph:**
   These films are to be taken after the tooth has been temporized and the rubber dam has been removed. **THIS FILM WILL ALSO BE TAKEN USING THE DIGITAL X-RAY SYSTEM.**

G. **Case Assessment:** All cases will be assessed to determine suitability for treatment in the student clinic. Normally, students will treat only cases classified as minimal difficulty (Class I). Only with the explicit approval of an instructor who will work with that student throughout the case, will students be allowed to treat higher classified teeth.

**CLINICAL PROFICIENCY IN ENDODONTICS**

**Clinical Eligibility:**
Successful completion of the Sophomore Pre-clinical Endodontic Course qualifies you to enter the endodontic clinic. New third year students **MUST** complete the manikin exercises and the diagnostic proficiency exam, in addition to assisting on at least one endodontic case to completion (cleaning and shaping and obturation) before actual treatment of the first patient. Use of the endodontic clinic is a privilege, which may be suspended for unsatisfactory clinical or didactic performance (professional attitude, actions and patient management). Reinstatement of clinical privileges is dependent on satisfactory completion of assigned remedial work. If a fourth year student lacks a satisfactory endodontic clinic experience during their third year, they will be required to complete a manikin exercise (for no points) before permission is granted to treat a patient in the endodontic clinic.

**Manikin Exercises:**
You must complete 4 extracted teeth satisfactory before you are allowed to see patients in the Endodontic Clinic. Extracted teeth must include an anterior (can be mandibular or maxillary), maxillary premolar, maxillary molar and mandibular molar. The extracted teeth must be done in the Endodontic Clinic with supervision by Endodontic faculty.

**Experiences Needed for Graduation**
Minimum requirements:
You must satisfactorily complete 4 teeth; 1 of which must be molar. (Grading protocol posted on Blackboard). You will not be allowed to schedule a molar until you have satisfactorily completed a case without any complications. All work must be done in the Endodontic Clinic with supervision by an Endodontic faculty. No credit will be given for cases completed outside of the dental school.
ENDODONTIC PAPERWORK REQUIRED TO OBTAIN GRADING & CREDIT

When you complete a case in Endodontics, the following papers are required:

1. Case History Chart, graded & initialed by a Faculty member on page one, and page two.
   
   Make sure that the patient name, your name & tooth number being treated along with your SOAP notes.

2. Informed Consent Form, signed & dated by the patient, the Student Doctor, & a Faculty member on page two.

3. All soap notes should be printed out.

4. The completed Evidence Base Documentation Form for clinical treatment must be filled out completely and turned in with the above paperwork as part of the final chart. (The student self-assessment of each case must be completed at the bottom of this form).

5. The Student Doctor must document post-operative telephone communication on the patient status and submit it in axiUm in patient chart.

Make sure that you have a copy of 1 - 5 above for your records. Please ensure that the proper procedure code has been entered into the computer, and the case has been swiped by a Professor. Also, have the PSR desk scan the paperwork for you prior to bringing it to the Endodontic Office. ALL OF THESE ITEMS MUST BE SUBMITTED TO ENDODONTIC OFFICE BEFORE CREDIT CAN BE RECEIVED.

The available paperwork is provided in folders in the Endodontic Clinic:

- PATIENT SATISFACTION SURVEY
- MEDICAL CONSULTATION REQUEST
- GENERAL PRACTICE RESIDENCY PROGRAM REFERRAL FORM
- DEPARTMENT OF ENDODONTICS REFERRAL FORM
- PATIENT WITH MEDICAL ISSUES (i.e., ANTI-COAGULENT THERAPY)
- COMMON PRESCRIPTION PROTOCOL
- ENDODONTICS COLLEAGUES FOR EXCELLENCE USE and ABUSE of ANTIBIOTICS
- DIAGNOSIS TESTING with ENDO ICE, HEAT, etc.
- RECORDING DATA
- EMERGENCY TREATMENT PROTOCOL
- ENDODONTIC PROTOCOL for PULPOTOMY
- EXAMPLE COMPUTER SOAP NOTES
- PATIENT EXCUSE
- DEPARTMENT of ENDODONTICS ANESTHESIA REQUIREMENTS
H. Remediation: Remediation can consist of oral examinations; student completion of case based examination questions and successful performance on the clinical proficiency evaluation. Remedial work will be required for any student not demonstrating clinical proficiency. Remedial work can consist of laboratory procedures performed on extracted teeth to include the “Manikin exercise”. The procedures performed will be at the instructor’s discretion and must be graded by two instructors. Credit may not be earned if an endodontic mishap occurs that results in referrals to Oral Surgery or an outside Endodontist. If indicated remediation is required before a new case can be initiated.

I. Recall examinations will be done on ALL your endodontic patients. Normal recall intervals will be six months, but may be shortened to three months if circumstances dictate so. Recall examinations will be done on patients that you have treated, to ensure proper restoration, and healing. Recall examinations will Include a digital radiograph; which will be compared to the original post-operative radiograph.

II. ENDODONTIC CLINIC CHECKLIST

- Set-up at least 20 minutes before your patient is due and check your instruments so that you will not have to run around the building, thereby interrupting the process and breaking the chain of asepsis. Being organized will also increase your patient’s confidence in your ability to perform root canal therapy. Remember that root canal therapy has received a reputation for being a painful procedure.

- Log each radiograph taken in the patient’s chart.

- Prepare to close your case 30 minutes before the clinic closes in order to allow time to write in the record and process radiographs.

- **Do not** use air, water, or sodium hypochlorite under pressure in an open canal. You could create an air emboli periapical or create a sodium hypochlorite accident.

- **Do not** use files in dry canals. You could create a Dentin Ledge that results in perforation while filing. To avoid mishaps, always use copious irrigation and always work in a wet canal.

- **Do not** use safe ended diamonds OR ANY BUR to “FIND” canal orifices. The endodontic explorer DG16 is designed to facilitate tactile sensitivity required for finding canals. Using burs to find canals or to remove excess tooth structure could thereby cause perforations and could necessitate extraction.
- All periodontal and restorative consults must be requested and determined, if needed, before starting a case.
Visual Check

- Look for mechanical damage, possibly affecting radiation safety.
- Inspect cone for possible cracks.
- Check the mechanical functions.
- Test the tubehead in all working positions for possible drift.
- Verify that all labels are affixed and legible.
- Dotted labels must be replaced.
- Include the above, write to Siemens Dental Systems (address, see rear)
- giving details on: Customer Name
- Customer Address
- All Model Numbers with
- Serial Numbers still legible on the unit for identification purposes.
- For serial numbers see also Installation Report / Warranty Passport.
PROTOCOL FOR USING A RAPID DEVELOPER BOX

DO NOT PLACE CONTAMINATED GLOVED HANDS THROUGH SLEEVES OF BOX!!!!!!

1. The visual method of development is used

2. If a plastic film cover is used, remove the cover and drop the clean film in a plastic cup. If no cover is on the film, wrap the film in a paper towel.

3. Raise the light filter cover

4. Place the film and a clip through the top of the box.

5. Close the light filter cover.

6. Insert ungloved hands (if a film cover was used) or clean gloves if no film cover was used.

7. Remove x-ray film from wrapper and place on film hanger. HANDLE THE FILM WITH THE EDGE ONLY DO NOT GET FINGERPRINTS ON FILM. ATTACH THE FILM TO THE CLIP ON THE EDGE ADJACENT TO THE DOT.

8. Immerse the film in the developing solution and slightly agitation several times. Developing is complete when a DEFINITE VISUAL IMAGE OF THE TOOTH APPEARS ON THE FILM. (FIRST JAR)

9. Rinses film in water for a few seconds to remove the developing solution. (SECOND JAR)

10. Immerse film in the fixing solution until the film is clear, rendering the image translucent. (THIRD JAR) Leaving the film in the fixer, close the top on the developer and fixer. Remove hands and open the light filter cover.

11. Rinse the film in water to remove the fixing solution. (FOURTH JAR)

# ENDODONTIC DEPARTMENT
## EVALUATION FOR "THE MANIKIN EXERCISE"

This check sheet is to be used for the manikin exercise. It is the student's responsibility to obtain each check required for the exercise. You should have read the section and requirements for the manikin exercise either in the pre clinical manual, the clinic information manual, or, a copy of the exercise obtained from the Endodontic department administrative assistant before beginning the exercise. **YOU WILL HAVE ONE CLINICAL PERIOD TO COMPLETE THE EXERCISE.**

### Student Name: __________________________ Date ____________

<table>
<thead>
<tr>
<th>STEP and CRITERIA</th>
<th>POINTS</th>
<th>SCORE</th>
<th>REASON(S) FOR DEDUCTION (Initial)</th>
<th>TRIAL LENGTH</th>
<th>WORKING LENGTH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Properly mounted tooth – Crown fully exposed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-operative radiograph - Wax visible at apex (Properly processed and mounted) 3 mm of &quot;bone&quot; visible past apex.</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unit and instrument check - (High &amp; slow speed hand pieces, endodontic explorer, spreader(D11T), plugger (9-11), cotton pliers, Glick # 1, film clips, files(stainless steel and NITI)), endo ring with sponge, Gates Glidden drills, irrigating syringe, iris scissors. Also, Rubber dam equipment for isolation.</td>
<td>5</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Rubber Dam – Must simulate covering both arches, and be leak proof.</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Access opening – Proper outline, occlusal reduction, all canals can be entered with the endodontic explorer.</td>
<td>10</td>
<td></td>
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</tr>
<tr>
<td>Working length – At least size 15 file, must be within 1mm of desired length. (Radiograph required)</td>
<td>10</td>
<td></td>
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</tr>
<tr>
<td>Cleaning and shaping – (Spreader fits to within 1-2mm of working length without force)</td>
<td>10</td>
<td></td>
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</tr>
<tr>
<td>Master cone fit - (Radiograph required) 0.5 to 1mm from radiographic apex, with cement in canal.</td>
<td>10</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Obturation - (Before cutting cones) Dense fill with no voids.</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Final condensation - (All gutta percha removed from chamber, gutta percha at least 3mm below orifice openings.) (Radiograph required)</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temporary filling – Cotton pellet in chamber, covered by at least 3mm of Cavit</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final evaluation – All radiographs properly processed, diagnostic and mounted in correct order</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature of Faculty ______________________________________ Score: ____________
### Sophomore SRTA
Grading for Anterior Tooth 0-4 points/Step

<table>
<thead>
<tr>
<th>Preop, Dx</th>
<th>WL</th>
<th>FMC</th>
<th>FO</th>
<th>X-ray</th>
<th>Total Pts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

**Criteria for Automatic Failure**

**ModuPRO® Sextant One**

- **Non-diagnostic Radiographs**: Failure to provide adequate postoperative radiographs of diagnostic clarity, also includes missing buccal/lingual and/or mesial/distal radiographs

- **Underfill (gutta percha)** greater than 1.5 mm (in reference to the radiographic apex)

- **Overfill (gutta percha)** greater than 0.5 mm (in reference to the radiographic apex)

- **Improper Seal, Apical 1/3**: Failure to adequately seal the apical 1/3, resulting in voids or gaps present in the gutta percha

- **Perforation**: Failure to keep the access opening within the proper boundaries of the crown or root

- **Excessive Access Opening**: Excessive access opening of a magnitude that compromises the structural integrity of the tooth

**Comments:**

(1 of 2)
<table>
<thead>
<tr>
<th>Access Opening</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Location</td>
<td></td>
</tr>
<tr>
<td>□ 5 points</td>
<td>The placement of the access opening reflects the position of the pulp chamber and allows for complete debridement of the pulp chamber and straight-line access to the root canal system.</td>
</tr>
<tr>
<td>□ 4 points</td>
<td>The placement of the access opening is not over the pulp chamber and hinders complete debridement of the pulp chamber and straight-line access to the root canal system.</td>
</tr>
<tr>
<td>□ 3 points</td>
<td>The location of the access opening is not over the pulp chamber, and hinders complete debridement of the pulp chamber. Pulp horns are not fully removed through the access opening.</td>
</tr>
<tr>
<td>□ 0 points</td>
<td>The location of the access is not over the pulp chamber, and does not allow complete debridement of the pulp chamber or access to the root canal system. Pulp horns are not entered.</td>
</tr>
</tbody>
</table>

| Total Points: |  |

<table>
<thead>
<tr>
<th>Size of the Opening</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 5 points</td>
<td>The access openings is of optimal size and allows for complete debridement of the pulp chamber without ledges remaining.</td>
</tr>
<tr>
<td>□ 4 points</td>
<td>The access opening infringes on the mesial marginal ridge, the oblique ridge and/or distal buccal cusp tips. The access opening allows for complete debridement of the pulp chamber and the cusps and/or marginal ridges have dentinal support.</td>
</tr>
<tr>
<td>□ 3 points</td>
<td>The access opening significantly infringes on the mesial marginal ridge and/or the oblique ridge and/or the mesial lingual and/or distal buccal cusps. The access opening is under prepared inhibiting complete debridement of the pulp chamber.</td>
</tr>
<tr>
<td>□ 0 points</td>
<td>The access opening grossly infringes on and/or undermines the mesial marginal ridge, the oblique ridge and/or the mesial lingual and/or distal buccal cusps. The access opening is underextended so that debridement of the pulp chamber is impossible or one or more canal orifice is not accessed.</td>
</tr>
</tbody>
</table>

| Total Points: |  |
J. **Unit Check:** Before you begin a treatment procedure, obtain your Endodontic records folder with the case history and treatment record on one side and the case assessment and risk assessment on the other side. The necessary forms are available upon entry to the clinic (see attached), and the consent form must be signed by the patient, student, and faculty before assessment begins.

Before you bring the patient to the operatory, the unit must be disinfected with sodium hypochlorite and you must have your unit and instrument check. Obtain all of your materials from the dispensary: Biohazard bags, chair cover, bracket table cover, brown paper (place on non-sterile area), light handles and air-water syringe covers, requisitions for anesthesia and x-rays, rubber dam, gauze, suction tips, safety glasses, gloves, face mask, and patient napkin. Each hand piece must be attached to the unit with protective covers. The instruments should be arranged exactly as the picture in the operatory.

Discuss the procedure with the clinical faculty and obtain permission to proceed; the instructor will initial your endodontic appointment record. Permission to proceed is required every time you see a patient in the Endodontic Clinic, regardless of the stage of treatment and includes any patient contact, even visits for consultation of minor adjustments.

Two current, diagnostic periapical radiographs of the tooth to be treated must be obtained in order to complete the assessment of the patient. **PATIENT BLOOD PRESSURE AND PULSE MUST BE RECORDED BEFORE TREATMENT BEGINS.**

K. **Post-treatment Evaluation:** When you have completed the endodontic procedure, mount all films in chronological order for case review and complete YOUR self-assessment of films. As a general rule, the films required will be:
   a. A pre-operative starting filming.
   b. Working length film.
   c. Master cone film.
   d. Condensations film.
   e. Completed case film (with a temporary filling in place and no rubber dam).

L. **Closing time:** All patients must be temporized (30) minutes prior to the official closing time. Endodontic clinic protocol prevents patients from being released from the clinic without proper instruction by the clinical faculty in charge. Certainty is made that proper medications are prescribed, and adequate temporary filling is placed, the tooth is out of occlusion and all x-rays and forms are completed and
signed. It takes some time to properly document the treatment record, additionally
time must be allowed to turn the operatories over, and turn in the charts. That means
11:30 for the morning clinic, and 4:30 for the afternoon clinic.

**GRADING**
(Protocol on Blackboard)

Satisfactory completion of each Endodontic case and grading is the result of:
  a. A composite evaluation of quality of radiographs.
  b. Diagnostic work-up and quality of instrumentation and the fill of the tooth involved.
  c. The amount of assistance received to complete the case.

Please note that a student may perform an excellent clinic treatment, but if the quality of
radiographs (processing, etc.), case write-up, or case presentation is average to poor, a lower
grade (fewer points) will be given.
Grading is based on a 20 point system with a maximum of (4) point per category. Whereas (15)
points is passing.
### Endodontic Case Difficulty Assessment

**Article III. Patient Name ____________________ Student: -**

<table>
<thead>
<tr>
<th>CRITERIA AND SUBCRITERIA</th>
<th>MINIMAL DIFFICULTY</th>
<th>MODERATE DIFFICULTY</th>
<th>HIGH DIFFICULTY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Patient Considerations</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical History</td>
<td>No medical problem  (ASA Class 1*)</td>
<td>One or more medical problems (ASA Class 2*)</td>
<td>Complex medical history/serious illness/disability (ASA Classes 3-5*)</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>No history of anesthesia problems</td>
<td>Vasocostricor intolerance</td>
<td>Difficulty achieving anesthesia</td>
</tr>
<tr>
<td>Patient Disposition</td>
<td>Cooperative and compliant</td>
<td>Anxious but cooperative</td>
<td>Uncooperative</td>
</tr>
<tr>
<td>Ability to Open Mouth</td>
<td>No limitation</td>
<td>Slight limitation in opening</td>
<td>Significant limitation in opening</td>
</tr>
<tr>
<td>Gag Reflex</td>
<td>None</td>
<td>Gags occasionally with radiographs/treatment</td>
<td>Extreme gag reflex which has compromised past dental care</td>
</tr>
<tr>
<td>Emergency Condition</td>
<td>Minimum pain or swelling</td>
<td>Moderate pain or swelling</td>
<td>Severe pain or swelling</td>
</tr>
</tbody>
</table>

**B. Diagnostic and Treatment Considerations**

| Diagnosis                        | Extensive differential diagnosis of usual signs and symptoms required | Confusing and complex signs and symptoms: difficult diagnosis | Extreme difficulty obtaining/interpreting radiographs (e.g., superimposed anatomical structures) |
|----------------------------------|-------------------------------------------------------------------|---------------------------------------------------------------|
| Minimal difficulty obtaining/interpreting radiographs | Moderate difficulty obtaining/interpreting radiographs (e.g., high floor of mouth, narrow or low palatal vault, presence of tori) | Extreme difficulty obtaining/interpreting radiographs (e.g., superimposed anatomical structures) |

<table>
<thead>
<tr>
<th>Position in the Arch</th>
<th>1st molar</th>
<th>Moderate inclination (10-30°)</th>
<th>Moderate rotation (10-30°)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anterior/premolar</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slight inclination (&lt;10°)</td>
<td>2nd or 3rd molar</td>
<td>Extreme inclination (&gt;30°)</td>
<td>Extreme rotation (&gt;30°)</td>
</tr>
<tr>
<td>Slight rotation (&lt;10°)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Tooth Isolation          | Simple pretreatment modification required for rubber dam isolation | Extensive pretreatment modification required for rubber dam isolation |                      |
|--------------------------|-------------------------------------------------------------------|---------------------------------------------------------------|
| Routine rubber dam placement |                                           |                                                              |                      |

| Morphologic Aberrations of Crown | Full coverage restoration | Porcelain restoration | Bridge abutment | Moderate deviation from normal tooth/root form (e.g., taurodontism, microdens) | Teeth with extensive coronal destruction | Restoration does not reflect original anatomy/alignment | Significant deviation from normal tooth/root form (e.g., fusion, dens in dente) |                      |
|----------------------------------|--------------------------|----------------------|-----------------|---------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|---------------------------------------------------------------|                      |
| Normal original crown morphology |                          |                      |                 |                                                              |                                                              |                                                              |                                                              |                      |

| Canal and Root Morphology                           | Moderate curvature (10-30°) | Extreme curvature (>30°) or S-shaped curve | Mandibular premolar or anterior with 2 roots | Maxillary premolar with 3 roots | Canal divides in the middle or apical third | Very long tooth (>25mm) | Open apex (>1.5 mm in diameter) |                      |
|----------------------------------------------------|-----------------------------|-----------------------------------------------|---------------------------------------------|----------------------------------|----------------------------------------------|--------------------------|----------------------------------|                      |
| Slight or no curvature (<10°)                      |                             |                                               |                                             |                                  |                                              |                          |                                  |                      |
| Closed apex (<1 mm in diameter)                    |                             |                                               |                                             |                                  |                                              |                          |                                  |                      |
| Moderate curvature (10-30°)                         |                             |                                               |                                             |                                  |                                              |                          |                                  |                      |
| Crown axis differs moderately from root axis, apical opening 1-1.5 mm in diameter |                             |                                               |                                             |                                  |                                              |                          |                                  |                      |

<table>
<thead>
<tr>
<th>Radiographic Appearance of Canals</th>
<th>Indistinct canal path</th>
<th>Canal(s) not visible</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Canal(s) visible and not reduced in size</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Canal(s) and chamber visible but reduced in size</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulp stones</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Resorption                                         | Minimal apical resorption |                      |                      |                      |                      |                          |                      |                      |
|----------------------------------------------------|--------------------------|----------------------|----------------------|----------------------|----------------------|--------------------------|                      |                      |
| No resorption evident                              |                          |                      |                      |                      |                      |                          |                      |                      |

**C. Additional Considerations**

<p>| Trauma History                                | Complicated crown fracture of mature teeth | Complicated crown fracture of immature teeth |                      |
|------------------------------------------------|--------------------------------------------|-----------------------------------------------|                      |
| Uncomplicated crown fracture of mature or immature teeth |                      |                                                |                      |
| Complication of mature teeth                  |                                            |                                                |                      |
| Subluxation                                    |                                            |                                                |                      |
| Horizontal root fracture                       |                                            |                                                |                      |</p>
<table>
<thead>
<tr>
<th>ENDODONTIC TREATMENT HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ No previous treatment</td>
</tr>
<tr>
<td>□ Previous access without complications</td>
</tr>
<tr>
<td>□ Previous access with complications (e.g. perforation, non-negotiated canal ledge, separated instrument)</td>
</tr>
<tr>
<td>□ Previous surgical or nonsurgical endodontic treatment completed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PERIODONTAL-ENDODONTIC CONDITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ None or mild periodontal disease</td>
</tr>
<tr>
<td>□ Concurrent moderate periodontal disease</td>
</tr>
<tr>
<td>□ Concurrent severe periodontal disease</td>
</tr>
<tr>
<td>□ Cracked teeth with periodontal complications</td>
</tr>
<tr>
<td>□ Combination endodontic/periodontic lesion</td>
</tr>
<tr>
<td>□ Root amputation prior to endodontic treatment</td>
</tr>
</tbody>
</table>

*American Society of Anesthesiologists (ASA) Classifications System
Class 1: No systemic illness. Patient healthy.
Class 2: Patient with mild degree of systemic illness, but without functional restrictions, e.g. well-controlled hypertension
Class 3: Patient with severe degrees of systemic illness which limits activity, but does not immobilize the patient.
Class 4: Patient will not survive more than 24 hours whether or not surgical intervention takes place.

Endodontic Classification:
Class I – All entries in minimum difficulty
Class II – One or more items in moderate difficulty
Class III – One or more items in high difficulty
BASIC CLINICAL SET-UP FOR ENDODONTICS

Pictured and named below are the instruments you should have on your bracket table. These are the ONLY things that should be on the table.
Mirror, endodontic explorer, endodontic spoon, spreader (D11T unless you are working on an anterior tooth), 9-11 plugger, Glick #1, cotton pliers(2), Iris scissors, endo ring with sponge and sterilized files and 6cc irrigating syringe and needle. Glyde, Root ZX™, and electric motor will be furnished by the department.

On your mobile cart or the table you should have the following instruments/equipment: (1) Nylon rubber dam frame. (2) Rubber dam punch and forceps. (3) Selection of clamps [# 3 for most molars #8 for molars not fully erupted or broken down], [#2 for premolars], [#9 butterfly for anterior], (4) hemostats, (5) film clips. High speed handpiece should be attached and checked to insure it is functioning properly.
Initial endodontic assessment requires a mouth mirror, cotton pliers, expro, tooth slooth, 2X2 gauze, cotton rolls, and cotton pellets.
I understand root canal therapy is a procedure used to retain a tooth, which may otherwise require extraction. Although root canal therapy has a very high degree of clinical success, it is still a highly technical biological procedure, therefore, neither Meharry nor its Department of Endodontics will guarantee the complete success of this procedure and will only warrant that the procedure is performed in harmony with the dental standards of care established by the American Association of Endodontics. I have been informed that due to the local conditions of the tooth and surrounding tissues, and very often because of systemic conditions, it might not be possible to successfully treat my tooth. Occasionally, a tooth that has had root canal treatment may require re-treatment, surgery, or even extraction. Periodically, minor complications may include pain and/or swelling. If this occurs, the patient is to immediately contact their student Doctor or call the following emergency number at (615) 341-4000.

All root canal therapy is associated with risks, such as:

1. Breakage of root canal instruments during treatment which may, in the judgment of the doctor, be left in the treated canal or require surgery for removal.

2. Perforation (extra openings in the crown or root of the tooth) of the root canal by instruments during treatment which may require additional surgical corrective treatment or result in premature tooth loss or extraction. Damage to bridges, existing fillings, crowns, or porcelain veneers. These may fracture during treatment and have to be replaced.

3. Loss of tooth structure in gaining access to canals.

4. Fracture of the crown and/or roots due to biting on the tooth during treatment or as a result of filling the canal. The tooth may be lost prematurely if this occurs.

5. Reactions to local anesthetic injections; severe allergic reaction in very rare instances that can be life threatening; changes in occlusion (biting); jaw muscle cramps and spasms; jaw temporomandibular joint (TMJ) difficulty, and/or trismus (restricted jaw opening) which usually last several days but may last longer.

6. After administration of local anesthesia and/or instrumentation of root canal; in rare instances paresthesia, numbness and tingling sensations in the lip, tongue, chin, gums, cheek and/or teeth may occur. This is generally transient, but on infrequent occasions may be permanent.

During treatment complications may be discovered which make treatment impossible, or which may require dental surgery. These complications may include; blocked canals due to fillings or prior treatment, natural calcifications, broken instruments, curved roots, periodontal (gum) disease, and/or splits or fractures of the teeth.

**Other Treatment Choices:** As a patient you may decline treatment, wait for more definitive development of symptoms, or decide to have a tooth extraction. Risks involved in these choices might include pain, infection, swelling, loss of teeth, and infection of other areas.
Consent: I, undersigned, being the patient (parent or guardian of minor patient), consent to the performing of the procedures decided upon to be necessary or advisable in the opinion of the doctor. I also understand that once I begin root canal therapy I must follow through promptly to complete therapy. If this is not done, I may experience pain, swelling, abscess, bone loss and/or premature tooth loss. I understand that following the root canal therapy, my tooth will be brittle and must be protected against fracture by placement of a crown (cap) over the involved tooth. I must return to my general dentist for this procedure. I understand that while root canal therapy has a high degree of success, no warranty or guarantee of success has been or can be given for root canal therapy.

**PLEASE NOTE**

MEHARRY MEDICAL COLLEGE SCHOOL OF DENTISTRY IS A TEACHING INSTITUTION, AND AS SUCH, STUDENT DOCTORS ARE SUPERVISED BY FACULTY AND PROCEDURES MAY TAKE AN EXTENDED PERIOD OF TREATMENT TIME

I have read the handout and brochure explaining my treatment. All of my questions have been answered. I fully understand the above statements, and I am freely signing this consent form.

_____________________________  ________________________
Patient/Parent/Guardian                  Date

_____________________________  ________________________
Student Doctor                        Faculty

(2 of 2)
For your protection, we perform a tissue biopsy anytime that we perform any type of outpatient surgery. This routine is done to ensure that there is not disease process beyond the injury or abscess that has brought you in to the office. Today, we will take a small tissue sample(s) that will be sent to a clinical lab for analysis. As it is extremely rare that this type of biopsy reveals any problems, we will call you only if your biopsy is NOT normal/negative.

Please be advised that there will be a laboratory fee for the analysis that is separate from any procedural charge from our office. This fee is usually covered by your Medical Insurance Provider and we encourage you to submit it to them for payment.

By signing below I agree that I read and understand the above statement. I understand that I will receive a separate bill from the clinical lab analyzing my biopsy sample.

Print Name ____________________________

Patient Signature______________________ Date ______________

Dental Assistant_______________________ Date ______________
Consent information sheet for Endodontic Treatment and Surgery

1. The nature of my endodontic treatment and surgery has been explained to me, and I am aware of the possible complication(s) involved. I agree that I have been given no guarantee or assurance of any specific results. ______________

2. Procedure: Medical necessary treatment for endodontic treatment and surgery on: Tooth / Teeth # ________________.

3. Alternative to Surgery: I understand that my treatment could have complications. The following has been discussed with me, by not limited to the following.
   - Injury to the nerves to the upper or lower lip and tongue causing numbness, which could possibly be permanent.
   - Bleeding and or bruising which may be prolonged.
   - Involvement of the sinus above the upper teeth.
   - Infection.
   - Injury to adjacent teeth or fillings.
   - Unusual reaction to medications given or prescribed.
   - Other: ________________

______________________________
Patient name (print)

______________________________  ________________________
Patient signature           Date            Witness            Date

(2 of 3)
I, or the minor for whom I am responsible for, are enrolled in the following Health Care Plan:

I understand that if appropriate, Meharry School of Dentistry will bill by Health Care Plan for services to be rendered. I also understand that Meharry School of Dentistry is authorized to bill me directly under the following conditions:

1. When I choose to receive services covered under my Benefit Plan without a referral and/or authorization from my Health Care Plan Provider.

   Because I am enrolled in a Health Plan, I must get a signed referral from my primary care physician and/or authorization from my Health Plan to receive covered services. If my Health Plan determines that I did not get a referral and/or authorization when I should have, I understand that I am responsible for payment for the services rendered.

2. When I receive services that are not covered under my Health Plan.

   If my Health Plan decides that the services I receive are not covered under my benefit policy, I will responsible for payment for the services rendered.

3. When I receive services from Meharry School of Dentistry which are covered by my Health Plan but are only reimbursable by the Health Plan if provided by a different provider.

   I understand that my Health Plan may choose to "carve out" certain services and require that I receive such services by a particular contracted provider. I further understand that if I am informed at the time of services that Meharry School of Dentistry is not a contracted provider for which reimbursement will be received, yet I choose to move forward with the services at Meharry School of Dentistry I will assume responsibility for the payment of such services.

My signature below indicates that I have read and understand the above. If any of the three before mentioned scenarios apply I will assume full responsibility for the fees associated with the services.

Print Name: ___________________________ Date: ___________________________

Signature: ___________________________ Witness: ___________________________

(3 of 3)
**ENDODONTIC CASE HISTORY**

### I. DENTAL COMPLAINT

<table>
<thead>
<tr>
<th>Present</th>
<th>None</th>
<th>Pain to Cold</th>
<th>Pain to Hot</th>
<th>Pain to Pressure</th>
<th>Spontaneous Pain</th>
<th>Intermittent Pain</th>
<th>Diffuse Pain</th>
<th>Localized Pain</th>
<th>Throbbing Pain</th>
<th>Continuous Pain</th>
</tr>
</thead>
</table>

### III. RADIOPHGRAPHIC EXAMINATION

<table>
<thead>
<tr>
<th>Po</th>
<th>chamber and Canal</th>
<th>Normal</th>
<th>Partial Calcification</th>
<th>Complete Calcification</th>
<th>Internal Resorption</th>
<th>External Resorption</th>
<th>Perforation</th>
<th>Broken Instrument</th>
<th>Incomplete Apical Driv</th>
<th>Incomplete R.C. Filling</th>
</tr>
</thead>
</table>

### IIII. PULPAL DIAGNOSIS

<table>
<thead>
<tr>
<th>Vital, Normal</th>
<th>Reversible Pulpitis</th>
<th>Irreversible Pulpitis</th>
<th>Necrosis</th>
<th>Previously Treated</th>
<th>CN</th>
</tr>
</thead>
</table>

### IV. PERAPICAL DIAGNOSIS

<table>
<thead>
<tr>
<th>Normal PDL</th>
<th>APP</th>
<th>CPP</th>
<th>APA</th>
<th>CDP</th>
</tr>
</thead>
</table>

### V. CLINICAL RECALL APPEARANCE

<table>
<thead>
<tr>
<th>Condition</th>
<th>Comment</th>
</tr>
</thead>
</table>

### VII. RADIOGRAPHIC RECALL EVALUATION

<table>
<thead>
<tr>
<th>PDL Infect</th>
<th>PDL Resistant</th>
<th>Decrease in Lesion Size</th>
<th>Lesion Size Decrease</th>
<th>Increase in Lesion Size</th>
</tr>
</thead>
</table>

---

**PATIENT**

**TOOTH NO.**

**PATIENT NO.**

**STUDENT DR.**

**DIAGNOSIS**

**CLAMP NO.**

**TX PLAN APPROVED**

**PATIENT CONSENT**

**TREAT IN PREDOCTORAL CLINIC**

**REFER TO OUTSIDE PRACTITIONER**

---

**Grading 0-4 points/ Step**

<table>
<thead>
<tr>
<th>Preop, Dx</th>
<th>WIL</th>
<th>FMC</th>
<th>FO</th>
<th>XRAY</th>
<th>Total PTS</th>
</tr>
</thead>
</table>

Student

Faculty

Aspects is expected throughout the procedure and points may be deducted if proper protocol is not followed.
## Patient Considerations

<table>
<thead>
<tr>
<th>Medical History</th>
<th>Objective Clinical Findings</th>
<th>Additional Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>cardiovascular disease</td>
<td></td>
<td>Restorability</td>
</tr>
<tr>
<td>cerebrovascular considerations</td>
<td></td>
<td>position challenge</td>
</tr>
<tr>
<td>bleeding disorders</td>
<td></td>
<td>findings</td>
</tr>
<tr>
<td>canal distortion</td>
<td></td>
<td>need for crown lengthening</td>
</tr>
<tr>
<td>medical prosthesis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>abnormalities in host defense</td>
<td></td>
<td></td>
</tr>
<tr>
<td>diabetes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>mental impairment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>acute systemic disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pregnancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>need for pre-medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>other systemic conditions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Local Anesthetic Considerations

- Vasovagal responses:
  - anesthetic allergy
  - history of difficulty in obtaining profound anesthesia

## Personal Factors and General Considerations

- limited ability to open mouth
- gagging
- fear of dentist
- motivation to preserve
- physical impairment - difficulty
- limited to be reclined
- size of mouth

## Trauma

- avulsion
- laceration

## Endodontic Case Difficulty Assessment

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Radiographic Findings</th>
<th>Additional Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>inconclusive or contraindicatory</td>
<td>difficulty in obtaining time of diagnostic value</td>
<td></td>
</tr>
<tr>
<td>findings</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- *Pulpal Space*:
  - calcification
  - chamber
  - orifice
  - canal
  - number of canals

- *Root Morphology*:
  - curvature
  - diastasis
  - length
  - curvature
  - short

- *Axial Morphology*:
  - open

- *Malpositioned teeth*:
  - buccal version
  - mesial or lingual

- *Perforations*:
  - Rate 3 only

## ASSESSMENT OF RISK

1. Complete the Endodontic Case Difficulty Assessment Form by evaluating risk levels and assigning a rating of (1) for average risk, (2) for high risk, and (3) for extreme risk for each entity.
   - **1=Average Risk**: Preoperative condition indicates average or routine complexity (uncomplicated) and no treatment or patient impediment factors. Achieving a predictable treatment outcome should be stainable by a competent student.
   - **2=High Risk**: Preoperative condition is complicated, presenting one or more treatment or patient impediment factors. Achieving a predictable treatment outcome will be challenging for an experienced student.
   - **3=Extreme Risk**: Preoperative condition is exceptionally complicated, presenting one or more difficult treatment or patient impediment factors. Achieving a predictable treatment outcome will be difficult for the most highly skilled student.

2. Review your evaluation of risks involved in this case to determine disposition. If any one or more factor is rated high (2) or extreme (3) risk, then referral outside the student clinic may be appropriate.

### CLASS I CASE: Any case which should be within the level of clinical competence expected of a general dentist at the time of their graduation from dental school.

### CLASS II CASE: Any case which could reasonably require the skills of a specialist, but which could be predictably completed by a general dentist who has had considerable endodontic experience and/or additional postgraduate endodontic training (GPR, etc.)

### CLASS III CASE: Any case which is not only difficult and recognizable beyond the skill level of the occasional provider of care.

Case Classification

Faculty signature

---

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Meharry Medical College, School of Dentistry
Patient Satisfaction Survey

Thank you for giving the Meharry School of Dentistry the opportunity to partner in your oral health care. The following survey will help us improve our services to valued customers like you.

The information that you provide will help us identify the strengths and weaknesses of the clinic services to our valued customers like you. We are interested in your personal opinion. The questionnaire that you are filling out is strictly confidential. Please do not write your name, or any other identifiable information on this form.

Instructions: For each of the following statements, please check (✓) the box that indicates your agreement or disagreement about the quality of clinic services provided by the faculty, staff, and students.

<table>
<thead>
<tr>
<th>Rating</th>
<th>1 = Strongly Disagree</th>
<th>2 = Disagree</th>
<th>3 = Unsure</th>
<th>4 = Agree</th>
<th>5 = Strongly Agree</th>
</tr>
</thead>
</table>

### A. About the Clinic

<table>
<thead>
<tr>
<th>1. When I arrive I was treated for care in a timely manner</th>
</tr>
</thead>
</table>

Comments:

<table>
<thead>
<tr>
<th>Rating</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
</table>

### B. About the Student

| 1. The student dentist communicated clearly |
| 2. The student dentist is helpful in explaining dental treatment |
| 3. The student dentist allows me to participate in the decision making regarding my dental care |
| 4. The student dentist was prepared, organized, and meticulous |
| 5. The student dentist was on time |

Comments:

<table>
<thead>
<tr>
<th>Rating</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
</table>

### C. About the Faculty

| 1. The faculty was on time |
| 2. The faculty communicated clearly |
| 3. The faculty is helpful in explaining dental treatment |
| 4. The faculty allowed me to participate in the decision making regarding my dental care |
| 5. The faculty was polite and courteous |

<table>
<thead>
<tr>
<th>Rating</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
</table>
Instructions: For each of the following statements, please check (✓) the box that indicates your agreement or disagreement about the quality of clinic services provided by the faculty, staff, and students.

1 = Strongly Disagree  2 = Disagree  3 = Unsure  4 = Agree  5 = Strongly Agree

**D. General Satisfaction**

<table>
<thead>
<tr>
<th>Rating</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> When I leave the clinic the dental instructions are clearly communicated</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2.</strong> I would recommend the clinic to others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3.</strong> I am satisfied with the quality of care in the clinic.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments:

**Additional Comments:**
Today's Date: 
Name of MD: 
MD Address: 
MD Phone: 
MD Fax: 

- This patient's reported medical condition makes it necessary for us to obtain written information and patient management directives from you.
- We must receive your written response on your letterhead before dental treatment can begin.
- Please do not fax or mail medical records.
- You may fax your reply to (615) 327-6067, ATTN: Mr. Donald Odom.

During the dental treatment this patient is likely to undergo, we normally expect:

**BLEEDING:** [ ] minimal [ ] moderate [ ] substantial

**STRESS:** [ ] minimal [ ] moderate [ ] substantial

Hypertension
At the dental exam on [ ] this patient's blood pressure was . The MMC School of Dentistry will not provide any dental treatment if the BP is above 180/105, will perform examination services only when the BP is between 165/95 - 180/105, and will provide most dental care services if the BP is below 165/95. Please evaluate this patient for appropriate medical interventions. We will follow our treatment guidelines unless we receive a written release from you indicating it is safe to treat this patient.

Cardiovascular Disease:
- [ ] Angina: Please indicate the frequency of angina episodes and whether or not this condition is stable. Also comment on the ability of this patient to undergo dental procedures with the indicated amount of stress.
- [ ] MI: Please indicate the date and severity of the myocardial infarct and comment on the ability of this patient to undergo the dental procedures with the indicated amount of stress. We generally wait 6 months post-MI before providing elective dental care services, unless you approve a shorter waiting period.
- [ ] Cerebral Vascular Accident: [ ] TIA's: Please indicate the location of the cerebral event and the extent of functional impairment. Also comment on the patient's ability to undergo the dental procedures with the indicated amount of stress.
- [ ] Cardiac Arrhythmia: Please indicate the type and adequacy of control. We generally administer 2% lidocaine with 1:100,000 epinephrine for effective anesthesia, and will use no more than 2 cartridges which is equivalent to 0.036 mg epinephrine. Does this patient's health status preclude the use of this anesthetic?

Antibiotic Prophylaxis
The documented increases in antibiotic-resistant microorganisms and allergic reactions in persons taking antibiotics necessitate the conservative use of antibiotics. Our goal at the MMC School of Dentistry is to prevent the unnecessary administration of antibiotics prior to dental treatment while providing antibiotic prophylaxis in those patients who are most at risk. Enclosed is a reference that lists cardiac and other medical conditions as well as various dental procedures for which antibiotic prophylaxis is and is not recommended. AHA and AAOS (American Academy of Orthopedic Surgeons) approved antibiotic regimens are included as well as other management recommendations. Please refer to this information as you respond to the following questions.

- [ ] Low to Moderate Risk Cardiac Condition: This patient reports a history of the following cardiac condition for which the American Heart Association recommends antibiotic prophylaxis: . This patient states that you recommend continued antibiotic prophylaxis prior to dental treatment. If this is the case, we request that you coordinate prescribing the antibiotics through your office. We have attached a summary of the 2007 AHA Guidelines for Prevention of Infective Endocarditis for your review.

- [ ] Other Systemic Conditions: This patient reports a history of . Please verify and/or clarify this condition and indicate whether or not antibiotic prophylaxis is needed prior to dental treatment associated with significant bleeding or bacteremia. If yes, we will prescribe antibiotic prophylaxis according to the 2007 AHA Guidelines. (See attached) If you recommend an antibiotic regimen inconsistent with these guidelines, please coordinate the prescribing through your office.

- [ ] Artificial Joint: This patient reports a history of artificial joint placement more than two years ago and no other risks for hematogenous prosthetic joint infection as defined by the American Academy/American Association of Orthopedic Surgeons. The patient states that continued antibiotic prophylaxis has been recommended that appears to be inconsistent with the current (1997) AHA Guidelines. Please advise if there are special considerations that might affect our decision on whether or not to prescribe prophylactic antibiotics. If you recommend an antibiotic regimen inconsistent with these guidelines, please coordinate the prescribing through your office.

Respiratory Disease:
School of Dentistry
General Practice Residency Program
Referral Form

Referred from ____________________________
To ____________________________

PATIENT INFORMATION:
Name: ____________________________________ Birth date: __________________________
Address: ________________________________ City: __________________________ State: __________________________
Telephone: ___________________________ Parents/Guardian: __________________________ Contact Number: __________________________

REASON FOR REFERRAL:
☐ CONSULTATION RE:

☐ TREATMENT (as requested):
*** (Please provide GPR Clinic with appropriate details of problems, i.e. urgency, areas of concern, tooth or teeth numbers).

☐ RELEVANT HISTORY:
**** (Indicates any special factors - either dental and/or medical - such as known allergies, specific medical problems relevant to the diagnosis and/or treatment)

Please check the appropriate box(es) below as it relates to this case:
☐ Patient needs a consult appointment
☐ Radiographs are enclosed
☐ Notify en completion
☐ Please report - written
☐ Patient needs post-referral maintenance

Comments: __________________________________________________________

_________________________ __________________________
Referring Faculty Name (PRINT) Department: __________________________
Signature Date

_________________________ __________________________
Student Doctor (PRINT) Classification: (circle one) D2 D3 D4
Signature Date
Referred To: __________________________________________________________

Patient Information:

Name: ______________________________________________________________

Address: _______________________________________________________________________

Telephone: _______________ Parent/Guardian: ___________________ Contact No.: ______

Reason for Referral:

________________________________________________________________________

○ Consultation Re: __________________________________________________________

○ Treatment (as requested):

  ***Please provide appropriate details of problems; i.e. urgency, areas of concern, tooth or teeth numbers.

_______________________________________________________________________________

_______________________________________________________________________________

○ Relevant History:

  ***Indicate any special factors-either dental and/or medical such as known allergies, specific medical problems relevant to the diagnosis and/or treatment.

_______________________________________________________________________________

Please check the appropriate boxes below as they relate to this case:

○ Patient needs a consult appointment
○ Notify on completion
○ Please report-written
○ Patient needs post-referral maintenance

Comments:

_______________________________________________________________________________

_______________________________________________________________________________

Referring Faculty Name (PRINT): _________________________________

Signature: ____________________________________ Date: _____________

Student Doctor (PRINT): _______________________________ Classification (circle): D3 or D4

Signature: __________________________________ Date: _____________
RELEASE OF RECORDS CONSENT

I,__________________________, hereby consent to the release of my medical records or any information regarding my health status to Meharry Medical College, School of Dentistry.

Patient’s Signature: ____________________________ Date: ____________________________

Date Sent: 12/12/2011  □ With patient  □ Faxed - By Init: ____________________________ Date: ____________________________

Received: ____________________________

Telephone Consultation:

Contact Person: ____________________________

Title: ____________________________

Student: ____________________________  Instructor: ____________________________
Endo-Ice® spray provides quick, easy, dripless, and very effective cold stimulus for testing pulpal health. Just follow these easy steps:

1. Remove the spray nozzle from the can of Endo-Ice spray. Insert the red extension tube into the nozzle securely and reattach the nozzle to the can.

2. Spray Endo-Ice spray directly onto a cotton pellet held by treatment trays until saturated. Do not spray in the vicinity of patient's face or onto tissue.

3. Touch the pellet to the facial surface of the tooth in question. Retract the lips and cheeks to avoid contact with the cold pellet.

4. Observe the patient's response and evaluate with other standard diagnostic criteria: medical and dental history; symptoms; clinical observations; tests; and radiographs may be included.

INSTRUCTIONS FOR USE

Green hygienic ENDO-ICE® spray is a profound refrigerant, utilized in dentistry for pulp testing. ENDO-ICE spray will elicit rapid pulpal response in vital teeth due to its low liquid temperature of -26.2°C (-15°F). It is non-flammable, non-explosive, convenient, easy to use and safe for dental procedures, used as directed. ENDO-ICE spray is environmentally safe, with zero ozone depletion potential.

Directions for use:

Securely attach the directional extension to the ENDO-ICE spray nozzle. Dry the teeth with gauze. Saturate a cotton pellet, held by locking pliers, with ENDO-ICE spray. Apply the cotton pellet to the middle third of the facial surface of the tooth in question, maintaining contact for several seconds or until the patient responds. Evaluate the patient's reaction, according to standard diagnostic criterion.

CAUTION: FOR PROFESSIONAL DENTAL USE ONLY

Do not spray directly into eyes, mouth or onto tissue. Not intended for use as a topical anesthetic. Use only as directed. Contents under pressure; do not puncture, incinerate or store above temperatures of 40°C (104°F).

Cautions: Federal law restricts this device to sale by or on the order of a dentist.

Net Weight: 6 ounces

Contains: 1, 1, 1, 2 Tetrafluoroethane, fragrance

Manufactured in the U.S.A. for:

Celitec/Whaledent, Inc.
Cuyahoga Falls, OH 44223 USA.
Antibiotics

1. Amoxicillin 500mg
   Disp: 28 (twenty-eight) tablets
   Sig: Take 1 (one) tab qid
   No Refills

2. Azithromycin “Z” Pack (Zithromax)
   Take As Directed
   No Refills

3. Keflex 500mg
   Disp: 28 (twenty-eight) tablets
   Sig: Take 1 (one) tab qid

4. Clindamycin 300mg
   Disp: 28 (twenty-eight) tablets
   Sig: Take 1 (one) tab q 6 hrs until gone
   (Remember GI issues with this drug)

Narcotics

1. Tylenol #3
   Disp: 12 (twelve) tabs
   Sig: Take 1 (one) tab q 4-6 hrs prn pain

2. Loratabs 5mg
   Disp: 12 (twelve) tabs
   Sig: Take 1 (one) q 4-6 hrs. prn pain
### RECORDING DATA

<table>
<thead>
<tr>
<th>Tooth/Canal</th>
<th>Reference Point</th>
<th>Working Length (mm)</th>
<th>Adjusted Working Length (mm)</th>
<th>Master Apical File (MAF)</th>
<th>X-ray</th>
<th>Fill</th>
<th>Last Rotary File Used</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
</tbody>
</table>

A notation indication file size includes tip diameter AND taper (ex.) 35/.02, or 45/.04, or 40/.06.
Evidence Based Documentation for Clinical Treatment

This form must be attached to the patient chart & why you’re doing what treatment you’re performing must be documented to receive credit for each Endo case. The purpose of this form is to document the latest scientific & clinical studies & procedures that support each step of your clinical treatment.

1. Diagnosis

2. Instrumentation

3. Obturation

4. Anti-Microbial Treatment (medicaments & irrigants)

5. Prognostic evaluation based on outcome studies

6. Special considerations such as calcified canals, perforation, other procedural errors in

7. Instrumentation & obturation

8. Recommendations for restorative, periodontal & additional treatment please list evidence based support for such. You’ve been provided numerous up to date articles on Blackboard in your didactic classes, these should provide a basis for these answers.

Student Doctor written self-assessment of completed Clinical Case:
Endodontics Emergency Treatment Protocol

The following protocol outlines management of the emergency dental patient related to Endodontic care. These steps are necessary to assure that patients presenting with pain are attended to in a timely and efficient manner. For situations that fall outside these guidelines, contact the Endodontic chairperson immediately for guidance.

1. For patients presenting to the Oral Diagnostic Sciences (ODS) Clinic with an endodontic symptom or indication, including abscess, pulpitis, periapical periodontitis, the student must check to see if the Endodontic Clinic is available.

2. An Endodontic consult must be requested when space is available in the Endo Clinic. If the Endo Clinic is not open, or all chairs are occupied or there is no facility available, relief of pain should be initiated (pulpotomy/pulpectomy, antibiotic, and pain control medication when indicated) in the ODS Clinic.

3. Prior to obtaining the Endo consult a complete medical/dental history & diagnostic work-up must be completed.

4. Teeth with an endodontic lesion and diagnosis require a written consult with the Restorative & Periodontal Department prior to bringing the patient to the Endo Clinic.

5. Once root canal therapy is initiated the Student Doctor must obtain the patient’s telephone number and follow-up with a telephone call to the patient that evening.

6. Prior to dismissal, the patient must be reappointed with the Endo Clinic with sufficient time necessary to complete the root canal therapy.

PLEASE NOTE: It is a mandatory requirement from the Endodontics Department to obtain a restorative & periodontal consult when indicated. If a student proceeds with RCT without the necessary consultations and documentation the student will not receive credit in Endodontics for the treatment. Further, if a student does not follow the proper protocol, it may result in a failing grade in Endodontics for the term.
The following is the new Protocol for performing a Pulpotomy. Attached is an article that supports the scientific basis for this treatment.

1. Administer appropriate local anesthesia. After anesthesia, a rubber dam is placed and access is obtained using a surgical length round bur size 2-8 depending on the tooth in question. (Use of other burs that are currently available for endodontic access are acceptable until next Fall when the new endodontic kits will be updated)

2. The pulp chamber must be completely cleaned and the orifice(s) to all canals must be exposed. (Pulpectomy can and should be performed if possible)

3. All canal orifice(s) must be identified and probed with an explorer.

4. Hemorrhage can be controlled by intra-canial injection of anesthetic. In addition Ferric sulfate on a cotton pellet that has been squeezed of excess can be placed. Several can be placed and allowed to set for 2 minutes. A black coagulation material will occur. All excess black coagulum should be removed using a Luer lock syringe and saline. If necessary a cotton pellet with a squeezed sodium hypochlorite solution will assist in the removal. Care must be taken to not re-stimulate the hemorrhage. If this occurs, another treatment of Ferric sulfate will be needed.

5. After the hemorrhage is completely stopped the chamber should be rinsed with water and dried. Alcohol on a cotton pellet can also be used.

6. A thick paste mix of Calcium Hydroxide mixed with saline is prepared and placed over the entire pulp chamber floor and orifice(s). Depending on the tooth and depth, 3-5 mm of material will be needed.

7. A thick mix of IRM cement is placed over the Calcium Hydroxide. This should fill the entire occlusal opening.

8. The tooth should be taken out of occlusion. Confirm with articulating paper.

9. The patient may be given prescriptions, analgesics and/or antibiotic if swelling is present. Faculty member in Oral Diagnostics can make this determination.

10. Student Doctors must obtain patients’ telephone number and call the patient within 24 hours to see how they are doing. The emergency telephone number should be given to the patient. The patient must be reappointed as soon as possible to the endodontic clinic for completion of root canal therapy.
EXAMPLE
COMPUTER SOAP NOTES

CHRONOLOGICAL RECORD OF DENTAL CARE

Restorations and Treatment [Completed at Meharry] [Ink entries] Subsequent diseases and abnormalities [Pencil entries]

SERVICES PROVIDED

<table>
<thead>
<tr>
<th>Date</th>
<th>Tooth #</th>
<th>ADA Code</th>
<th>Symptoms, Diagnosis, Treatment, Student/Faculty (Sign each entry with Student and Faculty Number)</th>
</tr>
</thead>
</table>
| 12-6-04 | 30      | 3330     | S: Patients chief complaint in their own words
My tooth on the bottom right hurts

O: What you view clinically
Gross decay on mesial of # 30. (Results of clinical vitality tests). Lingering response to cold # 30, 
#28, 29, 31, normal response. #30 very tender to percussion and palpation. (Radiographic 
interpretation) X-ray shows deep carious lesion that appears to involve pulp.

A: Pulpal and periapical diagnosis
Irreversible pulpitis, acute periapical periodontitis

P: What has been done today

Patient's Name
Meharry Medical College School of Dentistry
Chart Number
Treatment Record

SERVICES PROVIDED
PATIENT EXCUSE

Date: ______________________

This is to certify that:

Mr.  
Mrs.  
Miss.  ______________________

was a patient in the School of Dentistry, Meharry Medical College on  
__________________________ to receive dental services, and can report back to  
work/school on ______________________.

Faculty Name (Please print) ______________________  Faculty Signature ______________________

Comments: ______________________

__________________________

__________________________

__________________________

153
Department of Endodontics
Anesthesia Request Form

<table>
<thead>
<tr>
<th>Date:</th>
<th>Chart No.:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s Name:</td>
<td>Student Doctor:</td>
</tr>
<tr>
<td>Type of Anesthesia:</td>
<td>Number of Carpules:</td>
</tr>
<tr>
<td>Professor:</td>
<td></td>
</tr>
</tbody>
</table>
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17. The student Doctor must obtain patients’ telephone number and call the patient within 24 hours to see how they are doing. The emergency telephone number should be given to the patient. The patient must be reappointed as soon as possible to the endodontic clinic for completion of root canal therapy.
Maxillary Central Incisor

Average Length 23.3 mm
One canal 100%

A. Lingual view of recently calcified incisor
B. Distal view of same tooth
C. Cross sections at three levels
D. Large triangular shaped access preparation
E. Lingual view of adult incisor
F. Distal view of same tooth
G. Cross sections at three levels
H. Ovoid funnel-shaped access preparation
Maxillary Lateral Incisor

Average length 22.8mm

One canal 99.9%

Distal curve 53%

A. Lingual view of recently calcified incisor
B. Distal view of same tooth
C. Cross section at three levels
D. Large triangular shaped access preparation
E. Lingual view of adult incisor
F. Distal view of same tooth
G. Cross sections at three levels
H. Ovoid funnel-shaped access preparation
Maxillary Right Canine

Average length 26mm

One canal 100%

Distal curve 32%

A. Lingual view of recently calcified canine
B. Distal view of same tooth
C. Cross section at three levels
D. Ovoid funnel-shaped access preparation
E. Lingual view of adult canine
F. Distal view of same tooth
G. Cross section at three levels
H. Ovoid funnel-shaped access preparation
Maxillary First Premolar

Average length: 21.8 mm
Two canals: 55%
Distal curve: 37%

A. Buccal view of recently calcified 1st premolar
B. Mesial view of same tooth
C. Cross section at three levels
D. Ovoid access preparation
E. Buccal view of adult 1st premolar
F. Mesial view of same tooth
G. Cross section at three levels
H. Ovoid access preparation
A. Buccal view of recently calcified 2nd premolar
C. Cross sections at three levels
E. Buccal view of adult 2nd premolar
G. Cross section at three levels

B. Mesial view of same tooth
D. Ovoid access preparation
F. Mesial view of same tooth
H. Ovoid access preparation

Maxillary Second Premolar
One canal 75%
Distal curve 27%
Maxillary First Molar

Average length Palatal 20.6 mm
MB 19.9 mm  DB 19.4 mm

Four canals 56.5%

Palatal root
Buccal curve 55%

A. Buccal view of recently calcified 1st molar
B. Mesial view of same tooth
C. Cross section at two levels
D. Triangular access preparation
E. Buccal view of adult 1st molar
F. Mesial view of same tooth
G. Cross section at two levels
H. Triangular access preparation
Maxillary Second Molar

Average length: Palatal 20.8 mm
MB 20.2 mm DB 19.4 mm

Fused roots 48% Palatal root
Buccal curve 55%

A. Buccal view of recently calcified 2nd molar
B. Mesial view of same tooth
C. Cross section at two levels
D. Triangular access preparation
E. Buccal view of adult 2nd molar
F. Mesial view of same tooth
G. Cross section at two levels
H. Triangular access preparation
Mandibular Central and Lateral Incisor

- Average length
  Central 21.5 mm
  Lateral 22.4 mm

- Two canals (Central) 20.9%
- Distal curve 23%

A. Lingual view of recently calcified incisor
B. Distal view of same tooth
C. Cross section at three levels
D. Triangular funnel-shaped access preparation
E. Lingual view of adult incisor
F. Distal view of same tooth
G. Cross section at three levels
H. Ovoid funnel-shaped access preparation
Average length 25.2 mm

Dental Canine
One canal 94%
Distal curve 20%

A. Lingual view of recently calcified canine
B. Distal view of same tooth
C. Cross sections at three levels
D. Ovoid tunnel shaped access preparation
E. Lingual view of adult canine
F. Distal view of same tooth
G. Cross sections at three levels
H. Ovoid tunnel shaped access preparation
Mandibular First Premolar

Two canals 26%

Distal curve 35%

A. Buccal view of recently calcified 1st premolar
B. Mesial view of same tooth
C. Cross sections at three levels
D. Ovoid access preparation
E. Buccal view of adult 1st premolar
F. Mesial view of same tooth
G. Cross sections at three levels
H. Ovoid access preparation

Average length 22.1 mm
Mandibular Second Premolar
Two canals 13%

A. Buccal view of recently calcified 2nd premolar
B. Mesial view of same tooth
C. Cross sections at three levels
D. Ovoid funnel-shaped access outline
E. Buccal view of adult 2nd premolar
F. Mesial view of same tooth
G. Cross sections at three levels
H. Ovoid funnel-shaped access outline

Average length 21.4 mm
Distal curve 40%
Mandibular First Molar

Average length 20.9 mm

Four canals 28%  Mesial canal curves distally 84%

A. Buccal view of recently calcified 1st molar
B. Mesial view of same tooth
C. Cross sections at three levels
D. Distal view of same tooth
E. Buccal view of adult first molar
F. Mesial view of same tooth
G. Cross sections at three levels
H. Distal view of same tooth
I. Triangular (rhomboidal) access outline
Mandibular Second Molar

Average length 23.9 mm

Four canals 8%

One canal 13%

A. Buccal view of recently calcified 2nd molar
B. Cross sections at three levels
E. Buccal view of adult 2nd molar
G. Cross sections at three levels

I. Triangular (rhomboidal) access opening

B. Mesial view of same tooth
D. Distal view of same tooth
F. Mesial view of same tooth
H. Distal view of same tooth

*Illustrations in this section (pages 30-43) from "Endodontics", Fourth edition, Ingri & Bakland
Internal tooth morphology

The internal morphology of teeth is complex. Endodontic treatment involves the preparation and obturation of the entire root canal system. It is essential to have basic knowledge about the normal (expected) numbers of root canals and their shapes before the cleaning and shaping of these systems.

The incidence of multiple canals in each root is more prevalent than previously considered. Recent studies using techniques of tooth dissection, radiography, injection of dyes, etc., have helped to provide accurate details of the pulp space anatomy. This table represents a compilation of many reports on pulp space anatomy, and is what we will use as the guide.

<table>
<thead>
<tr>
<th>Tooth Type</th>
<th>Number of Canals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maxillary Incisor</td>
<td>Multiple canals rare</td>
</tr>
<tr>
<td>Mandibular Incisor</td>
<td>Single Root – One canal 60%</td>
</tr>
<tr>
<td></td>
<td>Single Root – Two canals 40% but only 2% have two (2) apical foramen</td>
</tr>
<tr>
<td>Maxillary Canine</td>
<td>Multiple canals rare</td>
</tr>
<tr>
<td>Mandibular Canine</td>
<td>Single canal – 80%</td>
</tr>
<tr>
<td></td>
<td>Two canals – 20%</td>
</tr>
<tr>
<td>Maxillary First Premolar</td>
<td>Single canal – 4%</td>
</tr>
<tr>
<td></td>
<td>Two canals – 90%</td>
</tr>
<tr>
<td></td>
<td>Three canals – 6%</td>
</tr>
<tr>
<td>Maxillary Second Premolar</td>
<td>Single canal – 70%</td>
</tr>
<tr>
<td></td>
<td>Two canals – 30%</td>
</tr>
<tr>
<td>Mandibular First Premolar</td>
<td>Single canal – 74%</td>
</tr>
<tr>
<td></td>
<td>Two canals – 25%</td>
</tr>
<tr>
<td></td>
<td>Three canals – 1%</td>
</tr>
<tr>
<td>Mandibular Second Premolar</td>
<td>Single canal – 90%</td>
</tr>
<tr>
<td></td>
<td>Two canals – 10%</td>
</tr>
<tr>
<td>Maxillary First Molar</td>
<td>3 roots &amp; 3 canals (MB, DB and P) – 50%</td>
</tr>
<tr>
<td></td>
<td>3 roots &amp; 4 canals (MB1, MB2, DB and P) – 50%</td>
</tr>
<tr>
<td>Maxillary Second Molar</td>
<td>3 roots &amp; 3 canals – 60%</td>
</tr>
<tr>
<td></td>
<td>3 roots &amp; 4 canals – 30%</td>
</tr>
<tr>
<td></td>
<td>2 roots &amp; 2 canals – 10%</td>
</tr>
<tr>
<td>Mandibular First Molar</td>
<td>Usually 2 roots</td>
</tr>
<tr>
<td></td>
<td>Mesial root – 98% 2 canals; 2% 1 canal</td>
</tr>
<tr>
<td></td>
<td>Distal root – 70% 1 canal; 30% 2 canals</td>
</tr>
<tr>
<td></td>
<td>Rare – 3 roots</td>
</tr>
<tr>
<td>Mandibular Second Molar</td>
<td>2 roots &amp; 3 canals – 40%</td>
</tr>
<tr>
<td></td>
<td>2 roots &amp; 2 canals – 35%</td>
</tr>
<tr>
<td></td>
<td>1 root and 1 canal – 25%</td>
</tr>
<tr>
<td>Maxillary and Mandibular Third Molar</td>
<td>Extremely variable</td>
</tr>
</tbody>
</table>

**These are approximate percentages to show trends or prevalence**
Department of Restorative Dentistry

The overall responsibility of the Department of Restorative Dentistry is to provide students with the knowledge, skills, and judgment necessary for the restoration of a physiologically functional and esthetic dentition. The department consists of two clinical divisions: (1) Operative Dentistry, (2) Prosthodontics within the division of Prosthodontics is Fixed and Removable Prosthodontics. There are two main restorative clinics: Operative and Prosthodontics.

STANDARD OF CARE

The Department of Restorative Dentistry strives to establish and maintain the highest standards of care in treatment of all patients. In the Operative Dentistry clinic, students are trained to become competent in diagnosis, prognosis, treatment planning, and treatment of defects of teeth that do not require full coverage restorations. In the Prosthodontics clinic, students are trained to restore damaged natural teeth and/or replace missing teeth and contiguous oral and maxillofacial tissues with artificial substitutes that provide function, comfort and esthetics.

- All patients will be treated in a professional manner at all times in the Restorative Clinics.
- Before a patient may be seated in the Restorative Clinics (Operative and Prosthodontics), the student must get approval from a faculty person in the Department, who must be present in the Clinic.
- The patients e-chart must be reviewed and updated prior to treatment, and this update includes:
  - Health history/medical alert status
  - Clinical Examination / Consultations
  - Assessment of vital signs
  - Radiographs
  - Treatment plan signed and accepted by patient
  - Informed consent – signed by patient
  - Student assignment (Documented by patient care coordinator)
  - Signed Privacy Acts (HIPPA) document on file
- No service may be provided to any patient without a faculty person present in the respective clinic at the time treatment is being rendered.
- Infection control policies and procedures must be followed and will be evaluated by the restorative faculty before, during and after treatment of each patient.
- All treatment rendered in the restorative clinics must be recorded in Axium® following each patient encounter and must be accurate, complete and approved by a Restorative Dentistry faculty person.
The use of a rubber dam is required for all preparations/restorative procedures unless alternative isolation procedures are approved by Restorative Dentistry faculty assigned to student.

**Clinic Hours:**

Restorative Dentistry clinic hours are from 8:00 a.m. to 12:00 noon and from 1:00 p.m. to 5:00 p.m. Students are expected to be present and on-time for all clinics. Faculty will be available for clinic coverage and student/patient assistance from 8:00 a.m. to 11:00 a.m. during the morning clinic session and from 1:00 p.m. to 4:00 p.m. during the afternoon session. Students are expected to seat patients within one-half hour after the clinics open. All clinical patient services must be completed by the deadline.

**Special Notes:**

1. Chair set up should be done in the morning – not the evening before the appointment.
2. Chair set up should be disassembled if there is a “no show” of the patient.
3. Chairs should be raised when procedure is complete and patient is dismissed.
4. All computer monitors should be shut off when finished.

Faculty will be available from 11:00 a.m. to 12:00 noon for signatures and to login, on the e-records, treatment services rendered during the morning session. All grading and signatures must be completed before 12:00 noon. Similarly, faculty will be available from 4:00 p.m. to 5:00 p.m. for signatures and to login treatment services rendered during the afternoon session. All grading and signatures must be completed before 5:00 p.m.

**Students who are late or who have late patient appointments will not be allowed to start clinic procedures in Restorative Dentistry unless prior approval has been obtained from the faculty assigned to the clinic floor.**

**Division of Operative Dentistry**

**A. POLICIES AND PROCEDURES:**

It is expected in performing total patient care, that the student will be exposed to various kinds of procedures. It is expected that the student will perform all services needed by the patient.

1. **Admittance into the Operative Clinic**

   Students having a patient for the Operative clinic must sign into the clinic using the logbook located in the dispensary area station. Once a student is assigned a cubicle, the
student signs his name and the patient’s name on the cubicle assignment sheet. ("Manikin" should be listed when the student is to perform a patient-simulation exercise.) If anything is malfunctioning in an assigned cubicle, the student should report it to the dental dispensary clerk or to the clinical instructor immediately.

If breakage or malfunctioning exists and is not reported, it will be assumed that the student using the unit caused it. Before using a unit, students should make sure that it is working properly. “No student will be allowed to change from one unit to another without permission from a clinic instructor”.

2. Treatment Plan and Radiograph Exposure Frequency

- Every student must have the patient’s electronic dental record available in the student operatory before any treatment may be performed.
- A current treatment plan is one no more than twelve (12) months old. On occasions, an updated treatment plan may be requested prior to twelve months, depending on the patient’s oral condition, change of treatment, etc.
- Referral patients with a current treatment plan do not require a new treatment plan if they are to be referred back to the original student.
- A new examination and treatment plan must be done under the following conditions:
  a. All new patients.
  b. Patients transferred from outside agencies or private practitioners.
  c. When existing treatment plan is over twelve months old.
  d. New bitewing radiograph should be taken at least every twelve (12) months or when indicated by a clinical instructor.
  e. In-direct restorative procedures should be completed in two clinical sessions (non-sequential, within a two-week period.
  f. Direct restorative procedures should be completed in one clinical session (3 hours).

3. Record Keeping

Students are responsible for recording all procedures performed at each appointment on the patient’s electronic record. Appropriate faculty signatures/approval must be secured and properly swiped into the e-record. When the student or the patient breaks an appointment, this too must be recorded in the patient’s e-record on that date, and verified by the clinical instructor.

4. Beginning a Procedure

Before a patient may be seated in the Operative Clinic, the student must get approval from a clinical instructor. The clinical instructor will evaluate the following:

1. The cleanliness of the screen in the suction apparatus and dental unit in general.
2. Foil/plastic properly placed on the handles of the operating light.
3. Sterilization of both the high speed and low speed handpieces and the hand instruments to be used during the procedure to be performed. (Instruments and handpieces should remain in the sterilization bag until the clinical instructor has approved them.)

4. Chair and work area must be covered with the appropriate sleeves and paper.

5. The mobile carts may be utilized as sterile area and should be covered with the appropriate paper. The bracket table is considered as a sterile area, white bracket covers should be used and only sterile instruments should be placed there.

6. The “non-sterile area” next to the sink should be covered with paper from the large roll provided. This area is considered as the workstation. NONSTERILE INSTRUMENTS OR SUPPLIES SHOULD BE IN THIS AREA.

7. No treatment may be performed on a patient without the availability of the patient’s e-records in the cubical. All patients must have a complete and approved treatment plan.

8. Prior to performing restorative treatment on a patient in the Operative Clinic, patients must have a periodontics release stating that restorative procedures may be performed. Patient may be required to have a prophylaxis prior to treatment even after receiving periodontics clearance depending on the circumstances and compliance with home-care instructions.

9. No student will be permitted to render a service to a patient unless the patient has been assigned to the student and the patient’s record reflects that assignment.

10. After a student has received approval to seat the patient in the cubicle and the patient e-record states that the patient is assigned to the student and the Treatment Plan has been approved and is current, the student may ask for a “Pre-Operative” evaluation which will allow the student to initiate treatment.

11. **Students should always remember that their authority to render service to the patient is based on their receiving approval, supervision and instruction from the clinical instructor.** Therefore, it is imperative for the student to be sure that all steps of the procedure have been evaluated and approved by a clinical instructor. Failure to do so may result in a severe penalty. **No service will be provided to a patient by a student without the authorization and supervision of the clinical instructor.**

12. **Students must perform a complete self-evaluation of all procedures completed on patients/manikins prior to the evaluations by clinical instructors. The self-evaluation is completed in Axium and evaluated by**
the instructor prior to the instructor’s evaluation. **Do Not** enter “OK” until an instructor has evaluated the student’s self-evaluation.

13. Only faculty members assigned to the Department of Restorative Dentistry may evaluate, approve, and grade patient services rendered in the Operative Clinic. This does not apply to off-campus patient treatment, which is authorized by the School of Dentistry.

14. Once the faculty evaluation is completed, the instructor will discuss with the student congruencies/discrepancies found in both evaluations.

**B. INSTRUMENTS AND SUPPLIES**

1. Students must have all instruments and supplies required for the clinical procedure available at the request of the faculty member at all times. **Failure to have these instruments or supplies will be taken into consideration when awarding grades.**

2. **Borrowing of instruments and supplies from other students will not be allowed.** Students who do not have proper instruments or supplies (or dull instruments) are in violation of clinical regulations.

**C. CENTRAL STERILIZATION**

1. Central Sterilization is the area for all students to obtain clinical sterilization of instruments.

2. All instruments for use on a patient must be autoclaved. **The autoclaved bags or cassettes containing the instruments must be opened in the presence of an instructor and arranged on the bracket table.** This will include burs and diamond cutting instruments.

**PAYMENT POLICY**

**PROCEDURES ON PATIENTS WITH AN OUTSTANDING BALANCE MAY NOT BE STARTED UNTIL THE BALANCE HAS BEEN PAID OR PAYMENT ARRANGEMENTS HAVE BEEN MADE.**

**D. AMALGAM RESTORATIONS**

1. All amalgam restorations must be performed with the use of the rubber dam unless specifically exempted by a faculty member where clinical conditions
preclude its use. If the rubber dam is exempted, isolation with cotton rolls or gauze is required during condensation and evaluations.

**THERE WILL BE NO EXEMPTIONS DURING A CLINICAL COMPETENCY EXAMINATION.**

3. The steps to be evaluated by the faculty member during the preparation and placement of an amalgam restoration are:

   a. Pre-operative preparation and instrument inspection
   
   b. Rubber dam application
   
   c. Removal of remaining caries (*not mandatory, unless base is used*)
   
   d. Cavity preparation
   
   e. Matrix adaptation
   
   f. Condensation and carving (*Full credit will be given when the amalgam has been condensed. However, standards of care require that all amalgam restorations must be finished and polished.*)

   f. Completed restoration (Finish and Polishing).

**E. GOLD/PORCELAIN INLAY/ONLAY RESTORATION**

1. All inlay restorations must be performed with the use of the rubber dam unless specifically exempted by the faculty member where clinical conditions preclude its use.

2. The fee for all gold inlay restorations must be paid before the inlay is placed. Only gold provided by the cashier may be used—*students are not allowed to use personal gold at any time.*

3. A bitewing x-ray is required prior to cementation of all inlays involving proximal surfaces when adjacent teeth are present and the cervical margin extends below the gingival margin and is not visible to clinical inspection.

4. All inlays must be properly polished, contact established, occlusion adjusted, and margins corrected prior to x-ray approval.

5. The steps to be evaluated by a faculty member during the preparation and cementation for an inlay restoration are:

   a. Pre-operative preparation and instrument inspection
   
   b. Removal of remaining caries
   
   c. Cavity preparation
d. Wax pattern  
e. Casting  
f. X-ray approval  
g. Pre-Cementation (ready to cement)  
h. Completed restoration (cementation removal, finish and polishing)

F. COMPOSITE RESTORATIONS

1. All composite restorations must be performed with the use of the rubber dam.

2. Etching of the enamel and/or dentin of all composite cavity preparations are required.

3. Steps to be evaluated by the faculty member during the preparation, placement and finish of a composite restoration are:
   a. Pre-operative preparation and instrument inspection
   b. Removal of remaining caries (when caries exceed the ideal depth)
   c. Cavity preparation
   d. Etching
   e. Condensation
   f. Completed restoration (Finish and Polishing)

G. GRADE LEVELS

Grade Point Calculations for all restorative procedures:

- **4.0 = A** (Excellent performance without faculty assistance)
- **3.5 = B+** (Good performance with or without faculty assistance)
- **3.0 = B** (Minimal clinical acceptability performance without faculty assistance)
- **2.5 = C+** (Minimum clinical acceptability performance requiring minimal faculty assistance)
- **2.0 = C** (Clinically unacceptable performance but correctable by the student with faculty assistance)
- **0 – 1.9 = F** (Major infractions or clinically unacceptable performance)
Major infractions for automatic failure:

a. Insufficient removal of decay
b. No contact when necessary
c. Open margins
d. Gross-over preparation of the tooth
e. Mechanical pulpal exposure
f. Mutilation of adjacent teeth and/or supporting structures
g. Unrecognized anatomic form, which is likely to case injury or destruction of periodontium
h. Improper sterilization and disinfection techniques
i. Failure to get faculty member evaluation and approval on any step
j. Procedure initiated on the wrong tooth
k. Unprofessional behavior/attitude

H. CLINICAL EVALUATION OF STUDENT PERFORMANCE

IT IS EXPECTED THAT STUDENTS WILL PROVIDE COMPREHENSIVE CARE ON ALL PATIENTS. In order to ensure that students receive adequate experiences in all of the areas related to Operative Dentistry, the following guidelines will be followed:

JUNIORS

1. Each student must have completed at least five (5) operative dentistry restorations on a live patient by the end of the junior year (including crown build-ups).
   *(For amalgam restorations, full credit will be given when the restoration is placed.)
   *(For composite restorations, full credit will be given when the restoration is placed and finished and polished.)

2. **Productivity:** Junior students must complete 50 points of productivity by the end of the junior year. This may be accomplished by combinations of:
   - Completion of restorations on live patients.
   - Completion of restorations on simulated patients.
   (*provided the requirements listed in #1 above has been satisfied.)

3. Final grade will be awarded based on the quantity and quality of restorations completed during the junior year (*1st and 2nd semester*).
   **Relative Grade Points (Quantity X Quality)**
   200 and above = A
SENIORS

Students must earn “200” points on procedures that are satisfactorily completed with a final passing grade “C” by the end of the senior year of clinics. This includes any and all points accumulated during the junior year. Fifty (50) points will be awarded for extramural rotations in the GPR, Emergency, and Extramural dental clinics. (These points will not be included in the calculations for final grades.)

Of the 200 points required, a minimum of “30” points in composite and a minimum of “50” points in amalgam should be accomplished in the operative clinic. Students who do not adhere to this will be evaluated individually and may be required to obtain additional experiences.

Grades are calculated based on the quantity and quality of clinical performance. The accumulative Specific Clinical Experiences (SCE) will be multiplied by the quality points achieved based on the above scale. This will equal the “Relative Grade Points” (RGP) to be used for the final grade tabulation.

Relative Grade Points (Quantity X Quality)

- 600 and above = A
- 525-599 = B+
- 450-524 = B
- 375-449 = C+
- 300-374 = C
- 0-299 = F

<table>
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<tr>
<th>Student Name:</th>
<th>Operative Dentistry Points</th>
<th>Average Grade for Operative Procedures</th>
<th>RGP’s</th>
<th>Final Grade</th>
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<tr>
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<td>C</td>
</tr>
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<td>200</td>
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Examples of possible grades:

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<th>Student Name</th>
<th>Operative Dentistry Points</th>
<th>Average Grade for Operative Procedures</th>
<th>RGP’s</th>
<th>Final Grade</th>
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<td>C</td>
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<tr>
<td>6. Sally Sue</td>
<td>200</td>
<td>2.0</td>
<td>400</td>
<td>C+</td>
</tr>
</tbody>
</table>

POINT SYSTEM (Relative Value Units):

One Surface Procedures 3 Points
(all anterior composite resins count as one surface)

Two Surface Procedures (proximal-occlusal) 4 Points
(includes amalgam, gold, porcelain and composite restorations)

Three or more Surfaces Procedures 5 Points

OTHER

Bleaching/tooth whitening 3 Points/patient
Veneers 5 Points
Crown Build-ups 5 Points

I. MANIKIN EXPERIENCES

All amalgam and composite resin procedures on the manikin must be completed in the same day to receive credit. Only one procedure may be started at a time. Students may not begin another procedure if one is already in progress.

The following procedures can be performed on the manikin:

**Junior Year**
- Two (2) Class II Amalgams (preparation and restoration)
- Two (2) Class II Posterior Composite resins (preparation and restoration)
-Two class III composite resins (preparation and restoration)

**Senior Year**
- Two (2) Class II Amalgams (preparation and restoration)
- Two (2) Class II Posterior Composite resin (preparation and restoration)
- Two class III composite resins (preparation and restoration)

**Senior Dental Students**

a. **Class II Amalgam Final Clinical Competency Examination (FCCE)**

   *This exercise must be completed on live patients.* Students must have completed a minimum of four (4) class II amalgam restorations on **“live patients”**, at the dental school, to qualify for this examination.

b. **Class III Composite Final Clinical Competency Examination (FCCE)**

   *This exercise must be completed on live patients.* Students must have completed a minimum of four (4) class III composite restorations on **“live patients”**, at the dental school, to qualify for this examination.

**K. GENERAL RULES**

1. To qualify for the FCCE the student must meet the following criteria:

   1. Must have completed at least:
      a. four class II amalgam restorations.
      b. four class III composite restorations.

   2. There must be an approved current treatment plan. (Except for those patients secured 24 hours prior to the competency examination)

2. Two faculty members must approve the tooth to be restored on the clinical competency examination. It is highly recommended that the student get the tooth approved prior to the date of the examination in order to avoid an unnecessary delay or the refusal to begin the examination.

   a. Rotated and supra-erupted teeth are usually not acceptable.

   b. The lesion to be restored should be clearly identifiable on the radiograph.

   c. A Class II amalgam Final Clinical Competency Examination may be performed on

      1. A carious tooth.
2. A tooth with a small simple existing occlusal restoration, but with interproximal caries.

d. A Class III Final Clinical Competency Examination may be performed on:
   1. A carious tooth.
   2. A tooth with an existing restoration that exhibits marginal leakage or recurrent decay.

e. **Cavity approval for amalgam restoration:** All Class II cavities to be utilized for the amalgam FCCE require that contact and occlusion are present with permanent restored opposing and adjacent tooth surfaces free of enamel breakdown. The use of cement for restored contour and contact will not be acceptable, but a cemented temporary crown is sometimes acceptable. **Removable teeth are not acceptable as contact teeth.** Occlusion may be artificial or natural dentition.

f. **Cavity approval for composite resin restoration:** Virgin lesions or those teeth containing existing Class III restorations must have contact with a natural tooth that has its enamel intact, or contact with a permanently restored tooth, or in some instances, cemented temporary crown. **Removable teeth are not acceptable as contact teeth.** Rotated teeth are usually not acceptable, however, in some cases; there might be an exception if the cavity is located in the area of the “clinical contact”.

g. All steps for the FCCE are evaluated in the same manner as required on all daily Clinical restorations performed in the Operative Dentistry Clinic.

h. **Students who fail An FCCE twice must undergo remediation before being allowed to take another clinical competency examination.**

i. Student must be assigned by the Department Chairman to a faculty member to complete their remediation. Remediation procedures **will not** be applied to the required points, but must be satisfactorily completed before a clinical competency can be retaken.

L. **BLEACHING/TOOTH WHITENING PROCEDURES**

All bleaching/tooth whitening procedures must be performed on patients who have a healthy periodontal condition as well as serviceable restorations.

The fee must be paid-in-full before the procedure starts.

A baseline shade is taken of the patient before the bleaching procedure. The patient is shown an educational video before the procedure. Information is given to the patient about the bleaching process. The length of treatment depends on the amount and the discoloration.
There is a minimum of two appointments for this procedure. The first appointment will include the making of impressions for the bleaching tray; baseline teeth shade documentation and the educational video showing of the bleaching procedure.

The second appointment will include delivery of bleaching trays with homecare instructions emphasized.

The patient should be rescheduled to return in a week for follow-up. This visit will include checking for any shade changes and sensitivity. If the target shade has been reached at this appointment, patient should be informed of any maintenance, which might be necessary.

(Note it is better to do one arch at a time so that patients can see the shade change)

- If it is necessary to start a bleaching case chairside, a faculty member will have to approve and assist.

Each case (not arch) count for three points

M. DENTAL AUXILIARY UTILIZATION (DAU)

A. CLINICAL ORIENTATION TO DENTAL AUXILIARY UTILIZATION (DAU)

First and Second year students will serve as chairside dental assistants when assigned.

Each student, on his first visit to DAU service, is to report directly to the faculty member in charge for assignment to a chair and to a dental assistant.

The trained dental assistant will work directly with the assigned students in a teaching capacity.

STUDENT WILL NOT BE PERMITTED TO WORK IN OTHER AREAS WHEN ASSIGNED TO DAU.

B. OPERATION OF THE DENTAL AUXILIARY UTILIZATION UNIT

Student on service will serve as chairside assistants for 3rd and 4th year students. The time should be used to work on patients, the manikin, reading and asking questions about topics in the DAU manual, learning how to communicate with assistant and becoming familiar with equipment. No excuses will be allowed for lack of participates when scheduled except for illness. The Dental Assistant and the DAU faculty member will monitor each student’s performance.

The dental assistant will be responsible for the orderly operation of the DAU units. The student and assistant are to simulate an office setting as much as possible. The assistants
will seat the patient. Students should be aware that the dental assistant also gives instructions relative to DAU principles.

Students are expected to use the full amount of time assigned, however, you are not to encroach on any other student’s time for DAU rotation. Proper utilization of your time is essential.

C. TIME MANAGEMENT

Management of time is a part of the correct utilization of an assistant. Therefore, to maximize efforts, all DAU students must be on-time for clinic rotations. DAU students will perform chairside assisting duties as instructed by the DAU Faculty, Certified Dental Assistant patient and the 3rd or 4th year student clinicians. TREATMENT should be started fifteen (15) minutes after the clinic opens and should be finished one hour prior to closing of the clinic.

D. DISTRACTIONS

Student operators and assistants should limit their conversation and activity to topics/subjects related to management and treatment of the patient.

E. EVALUATION OF STUDENT

1. Satisfactory performance of DAU principles.
2. Being present and on time for service rotations.
3. Patient and Auxiliary Management

F. FINAL DECISIONS

Any problems confronting a student while on DAU service for which there is not readily available regulation is to be resolved by the DAU faculty member in charge.

Adherence to the above regulations and close cooperation by the student and personnel involved will insure a worthwhile clinical exposure for both parties in the efficient practice of dentistry.

N. EXAMPLES OF SOAP NOTES FOR OPERATIVE DENTISTRY:

(Example 1)

SOAP Notes for Amalgam Restorations
Subjective Information

S – Patient has a sharp pain in Tooth #3. The pain is intermittent. “Sometimes it hurts, but not always.”

Objective Information

O – Vital Signs:
   Blood Pressure-136/84
   Pulse-64
Radiographs-mesial carious lesion on #3. No swelling in the area of #3.

Assessment

A – The patient is in need of an Amalgam restoration with base material.

Plan of Treatment

P – 2% Lidocaine (36 mg), with 1:100,000 Epinephine.
   Rubber Dam placed.
   Excavate carious lesion and placed Ca(OH) or Lime Lite base material and condensed and carved MO Amalgam restoration for tooth #3.

(Example 2)
Example of SOAP note for a composite restoration:

Subjective Information

S – Patient presents to the Restorative Clinic with the chief complaint, “I need my front tooth fixed, it is sensitive sometimes”.

Objective Information

O – Intra-oral evaluation of tooth # 9 reveals moderate carious lesion on distal of tooth # 9. Radiograph of # 9 has radiolucency on distal # 9 that does not extend to the pulp. Pt’s BP – 120/90, Pulse – 90. No change in medical history since last dental visit.

Assessment

A – #9 reversible pulpitis
Plan of Treatment

P – Pt. given 36 mg of 2% xylocaine with 1:100,000 epinephrine. Decay removed & a Class III DLF composite preparation completed on tooth #9. Tooth acid etched ,bonding agent placed And tooth restored with shade A-2 composite.

NV: Operative Clinic for restoration of tooth # 10

Division of Prosthodontics

These are simple rules and regulations that are related to the Division of Prosthodontics exclusively. Patient treatment and student conduct in the Prosthodontics clinic will be governed by the protocol outlined in this manual. Read the following rules carefully as they will be strictly enforced.

It is the student’s responsibility to secure the necessary patients from the Patient Services Representative (PSR) needed to fulfill the clinical experiences that are outlined by the department. When a patient is available, PSR’s will make assignments to students on the basis of student needs.

Once a patient is assigned to a student this becomes the student’s patient for the remainder of the student’s time in school. The patient can only be reassigned to another student by the PDR’s.

A. CHAIR ASSIGNMENT

1. Students having a patient for Prosthodontics service must sign into the clinic using the logbook located in the instructor station area. A clinical instructor will ensure that the student/patient has a valid appointment. The student must request a cubicle assignment from a Prosthodontics Clinical Instructor.

2. No cubicles (departmental) will be used without the student’s name being placed on the assignment sheet. Each chair that is being used by the student in the department must be cleaned before and after each operation. This cleanliness should include the chair, bracket table traps, and sinks as well as the entire cubicle (including floors).

3. Prior to seating the patient, the student will:
   a. inspect the dental cubicle
   b. ensure appropriate armamentarium for proposed treatment (see list of armamentarium posted on the bulletin board)
   c. be prepared to present synopsis of treatment plan
   d. check financial status of the case
   e. request necessary materials/supplies for the dispensary
   f. secure permission from an instructor to seat the patient

4. The faculty must evaluate the procedures performed and give permission to dismiss the
patient. At no time will a patient be dismissed from the clinic without expressed permission from the clinical instructor.

6. A Treatment Planning and Diagnostic work-up appointment in the Prosthodontics clinic must be completed prior to appointing a patient for actual definitive treatment (tooth preparation).

B. RECORDS AND CHARTS

No student will be permitted to bring a patient to the Prosthodontics clinic without the patient’s e-records readily available in the cubical.

1. Each procedure that is completed should be evaluated and approved by an instructor immediately after completion.  
2. The student must request that the instructor sign all procedures completed or will be required to repeat that procedure so as to document that the procedure has been completed at an acceptable level. The student will not be allowed to progress to the next procedure if the previous procedure has not been evaluated and approved.

C. PAYMENT OF FEES

1. A fee must be assessed for each prosthesis and 1/3 of the total cost of the prosthesis must be paid to the cashier before starting said work. The next third should be paid as follows: Complete dentures when selecting teeth; fixed and removable partial dentures BEFORE or at the final impressions appointment. The full amount for the prosthesis must be paid BEFORE delivery. It will be necessary to have two-third of the cost of the prosthesis paid before sending cases to the laboratory. The total fee for all Fixed Prosthodontics procedures must be paid before temporary cementation of the prosthesis.

2. Laboratory work authorizations should be completed in Axium. A copy must be printed, signed by the instructor and cashier, and presented to the dispensary along with the patient’s case.

3. Instructors are available to evaluate and assist the student in carrying out laboratory procedures. It is the policy of the department to consider the laboratory work as an essential part of the overall education of the student in the area of prosthodontics.

D. RULES OF CONDUCT

Observe all rules and regulations of the Department of Restorative Dentistry and the School of Dentistry.
Professional conduct in keeping with a person in a professional school of dentistry.

- Students should address patients with proper title (such as Mr., Mrs., Dr., etc.)
- Disposable clinic jackets must be worn when working in the laboratory or clinic respectively.
- Disposable clinic jackets must be changed as often as necessary for a neat appearance.
- The care and cleanliness of the work area are the student’s responsibility.

Clean brown paper must be on the desk at all times. This paper can be found in the dispensary and the support laboratory.

Stone and plaster must be mixed and used only in the areas provided for this purpose except where authorized by the supervising faculty in charge of the case. These materials are expensive, please do not waste them.

Take care to avoid damage to the desks and laboratory equipment. Any damage to the equipment should be reported immediately to the dispensary clerk or clinical faculty.

Care should be taken in mixing the gypsum products at the sink. **Do Not rinse raw gypsum products down the sinks!!!** These materials clog up the sink. Please remove excess materials from the sink immediately after mixing them.

Barring extenuating circumstances, the same instructor will re-evaluate work after corrections have been recommended and completed.

No loud or profane language is to be used in the laboratory or clinic.

1. The student is held responsible for the necessary instruments to carry out the various clinical laboratory procedures. Anticipation of the necessary instruments needed is expected. If the student does not have the necessary armamentarium, he/she may be asked to dismiss his/her patient. A list of armamentarium for each procedure is posted in the prosthodontics clinic.

2. The student is expected to have the basic knowledge of the procedure to be done. Failure to demonstrate adequate knowledge about the procedure will result in dismissal of the patient and student from the clinic immediately.

3. Proper safety precautions should be maintained at all times. Protective eye wear must be utilized whenever operating a rotatory instrument.

4. **No patients are allowed in the Support Laboratory.**

5. No patients should be examined in the hallways, on the stairways or in the waiting
areas by the students. All patients for examination or treatment should be seated in the prosthodontics clinic. No visitors (such as wives, children, guests, etc.) are allowed in the clinic/laboratory areas without the faculty approval. This is for safety purposes as well as legal protection for the student and the school.

6. Using tongue depressors to mix impression materials is prohibited and will result in dismissal from the dental clinics as well as not allowing credit for the procedure.

7. Students must report and fill out a repair requisition for any malfunctioning equipment and maintain cleanliness of his/her cubicle. No water, wax or trash will be permitted on the clinic floor.

8. Students must have proper attire as described in the student handbook. Students must also have legible name tags in the classroom, clinic and laboratory.

9. Violation of any of the above regulations will result in dismissal from the dental clinics or referral to the Associate Dean for Clinical Affairs for the appropriate action.

E. CLINICAL AREAS

Clinical procedures should be biologically oriented and performed with high ethical standards. The student is expected to be familiar with each clinical procedure to be completed. This knowledge should be based upon an overall view of the relationship of these procedures in the fabrication of the prosthesis. Each procedure should follow a step by step sequence as detailed in a preclinical course, or as currently detailed by an instructor. **The student is not allowed to proceed to another step until the preceding step is evaluated and signed by the instructor.** This step by step procedure in the clinical development of the prosthesis is intended to give the student a better understanding of the value and importance of the sequence of steps in the practice of prosthodontics.

**ANY STUDENT COMING TO THE CLINIC UNPREPARED (HAVING NO KNOWLEDGE OR THE PROCEDURE TO BE PERFORMED OR NOT HAVING THE PROPER ARMAMENTARIUM), AT THE INSTRUCTOR’S DISCRETION, WILL BE ASKED TO LEAVE THE CLINIC (DISMISS THE PATIENT) UNTIL HE/SHE BECOMES FAMILIAR WITH THE PROCEDURE THAT IS TO BE PERFORMED (AT THE INSTRUCTOR’S DISCRETION) OR HAS THE NECESSARY INSTRUMENTATION.**

The student is permitted to work in only one quadrant of the mouth when performing Fixed Prosthodontics procedures, unless treatment involve the maxillary anterior segment. (The decision to cross the midline is left up to the discretion of the clinical faculty member in charge.) The maximum number of units that may be fabricated simultaneously is four.

- All students that fabricate a post-and-core foundation for a patient must also complete the crown on the tooth to receive the credit points for the post and core.
- Mounted diagnostic casts, with diagnostic waxing and/or RPD survey/design are
required for all cases fixed and removable partial denture prosthodontics cases.

- Final impressions for fixed prosthodontics will not be allowed until a provisional restoration has been completed and approved by the clinical instructor.
- Final impression must be completed by 10:30 a.m. for the morning session and 3:30 for the afternoon session.

F. CLINICAL CASE ASSIGNMENT

Cases are assigned in the Prosthodontics Clinic according to the following guidelines:

- The student must present the patient’s case or potential treatment to the attending faculty for evaluation and acceptability as a treatment case in the undergraduate clinic.
- The student must have full knowledge of the total treatment plan for the patient with which he/she presents. The student must be able to discuss the interrelationship of the treatment proposed in the various disciplines and the logical reasons for the Treatment Sequence outlined for the patient.
- Before commencing treatment on the Fixed Prosthodontics and Removable Partial Prosthodontics case, the student must have diagnostic radiographs and study casts mounted on the Hanau articulator. All complete denture patients must have a panoramic radiograph before case assignment.

G. TIME OF CASE TREATMENT

All prosthodontic cases* should be completed within two months of the time the case is started. If the case is not completed within the designated time, the student’s progress will be reviewed by the chairman (with consultation of Prosthodontics faculty) who will determine the necessary course of action at that time. This will be directly correlated with the student’s evaluation in this discipline.

Student will not be allowed to start a new case when he/she has a case which has not been completed within the designated time span. All prostheses must be delivered a minimum of one week prior to the closing of the dental clinics so as to provide time for there necessary adjustment of case.

ALL ADJUSTMENT APPOINTMENTS MUST BE MADE AND AGREED UPON BY THE PATIENT BEFORE A PROSTHESIS CAN BE INSERTED IN THE PROSTHODONTICS CLINIC.

H. COMMERCIAL LABORATORY COMMUNICATION

All laboratory communication must be between the laboratory personnel and the faculty/staff in the department of Prosthodontics.
Direct communication between the student and laboratory personnel is prohibited.

Violations of this provision will mean that the student must complete the prosthesis but will be subject to disciplinary action as determined by the chairperson in consultation with the involved faculty person and the Associate Dean for Clinical Affairs.

All fixed Prosthodontics cases must be fabricated up to the impression stage. Opposing cast and appropriate interocclusal records must accompany each case. A work authorization must be completed and signed by the student and the clinical faculty member.

- Completed cases are turned in to the dispensary clerk in the Prosthodontics clinic for quality assurance evaluation before submission the appropriate commercial laboratory.

*Cases not meeting minimum submission standards will be returned to the student for appropriate corrective actions.

I. LEVEL OF CLINICAL PERFORMANCE

A combination of competency-based clinical treatment experiences and practical examinations, in both fixed and removable prosthodontics, will be used to determine the competency level of the student. The student/patient encounters in prosthodontics will occur under the comprehensive patient care concept. Prosthodontics credit will be given only for cases completed in the Department of Restorative Dentistry. The Chairman of The Restorative Dentistry Department will consider recommendations relative to credit for clinical progress of dental students from faculty of other departments in the School of Dentistry.

J. CLINICAL CRITERIA TO ASSURE THE COMPETENCY LEVEL OF THE GRADUATE.

Students are expected to complete the treatment of the patients assigned to their care. Patients accepted for treatment in the student clinics must agree to a comprehensive plan of treatment. Patient assignment is based on the student’s clinical experience needs and capability to manage treatment.

K. FIXED PROSTHODONTICS

A total of 50 Relative Value Units (RVU) are required by the end of the senior year. An overall minimum grade of 2.0 (“C”) must be achieved for each procedure in order to receive credit. A student that has completed the minimum RVU at a 4.0 (“A”) level may receive an additional RVU.
Example total number of RVU for each Specific Clinical Experience

<table>
<thead>
<tr>
<th>Procedure</th>
<th>RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>A single crown</td>
<td>2</td>
</tr>
<tr>
<td>A (three-unit) FPD</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>(retainer = 4 and pontic = 1)</td>
<td></td>
</tr>
<tr>
<td>A custom cast post and core</td>
<td>4</td>
</tr>
<tr>
<td>A prefabricated post and core</td>
<td>3</td>
</tr>
<tr>
<td>A post cementation recall</td>
<td>1</td>
</tr>
<tr>
<td>Comprehensive patient care</td>
<td>5</td>
</tr>
</tbody>
</table>

Minimum RVU
- 12 RVU from single crowns
- 18 RVU from fixed partial dentures
- 4 RVU from custom post and core*
- 3 RVU from prefabricated post and cores*
- 8 RVU from post cementation recalls

Additional RVU
- 5 bonus RVU are given if the minimum RVU are performed at a 4.0 ("A") level
- 5 bonus RVU are given for comprehensive patient care

*The student performing the procedure must complete the final restoration to receive credit.

Failure to complete the minimum RVU/completed patients minimum by the end of the fourth year will necessitate the student’s return to the clinics for subsequent patient care following the fourth year.

**Junior Dental Student**

Each student must have completed at least one Specific Clinical Experience (SCE) by the end of the spring semester 2013 to be considered to be making satisfactory progress. (to include crown build-ups)

**Senior Dental Student**

After satisfactory completion of 4 single tooth preparations or retainers, one of the remaining SCEs will be selected by the student for the Final Clinical Competency Examination. Each student must complete the FCCE with a minimum evaluation of “C” (clinically satisfactory). The competency exercise allows the student to demonstrate proficiency in patient selection, treatment planning, diagnostic work-up, tooth preparation, provisional restoration and impression making, laboratory work
authorization, and delivery of the prosthesis. The exercise must be completed in maximum of five (5) appointments.

L. REMOVABLE PROSTHODONTICS

A total of 40 Relative Value Units (RVU) are required by the end of the senior year. An overall minimum grade of 2.0 (“C”) must be achieved for each procedure in order to receive credit.

Example total number of RVU for each Specific Clinical Experience

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>RVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>A single cast based removable partial denture (RPD)</td>
<td>4</td>
</tr>
<tr>
<td>A single complete denture (maxillary or mandibular)</td>
<td>3</td>
</tr>
<tr>
<td>A single immediate denture (maxillary or mandibular)</td>
<td>4</td>
</tr>
<tr>
<td>A denture adjustment</td>
<td>1</td>
</tr>
<tr>
<td>A flexible partial denture</td>
<td>3</td>
</tr>
</tbody>
</table>

Minimum RVU
- 8 RVU from removable partial dentures
- 15 RVU from complete dentures
- 7 RVU from 24 hour denture adjustments
- 7 RVU from 48 hour denture adjustments

Additional RVU
- 1 bonus RVU is given for each 72 hour adjustment

Failure to complete the minimum RVU/completed patients minimum by the end of the fourth year will necessitate the student’s return to the clinics for subsequent patient care following the fourth year.

M. FINAL CLINICAL COMPETENCY EXAMINATION (FCCE)

1. Complete Denture Prosthodontics FCCE*
2. Fixed Prosthodontics (single crown) FCCE**
3. Removable partial Denture Prosthodontics ***

*Each student must complete one complete denture FCCE exercise with a minimum acceptable evaluation of “C” (clinically satisfactory). After satisfactory completion of four (4) units of complete dentures, the fifth complete denture unit can be selected by the student for the FCCE exercise. If the student chooses a combination (complete denture-partial denture) case, the RPD can be included in the minimum required SCE’s and/or as the RPD FCCE if the student is eligible for this exercise. The student should notify the attending faculty (on the clinic floor) of their desire to participate in
the competency exercise. **Faculty must note on the grade sheet that this procedure in an FCCE.** This competency exercise allows the student to demonstrate proficiency in patient selection, treatment planning, diagnostic work-up, impression making, and establishment of functional occlusal relationships, laboratory work authorization, and delivery of the prosthesis. The exercise must be completed in maximum of five (5) appointments.

**Each student must complete one crown FCCE exercise with a minimum acceptable evaluation of “C” (clinically satisfactory). After satisfactory completion of 4 single tooth crown restorations or fixed partial denture, one of the remaining SCEs will be selected by the student for the competency exercise. The student should notify the attending faculty (on the clinic floor) of their desire to participate in this competency exercise. Faculty must note on the grade sheet that this procedure in an FCCE.** The competency exercise allows the student to demonstrate proficiency in patient selection, treatment planning, diagnostic work-up, tooth preparation, provisional restoration and impression making, laboratory work authorization, and delivery of the prosthesis. The exercise must be completed in maximum of five (5) appointments.

***Each student must complete one Removable Partial Denture FCCE exercise with a minimum acceptable evaluation of “C” (clinically satisfactory). After satisfactory completion of one RPD, the remaining SCEs will be selected by the student for the competency exercise. The student should notify the attending faculty (on the clinic floor) of their desire to participate in the competency exercise. Faculty must note on the grade sheet that this procedure in an FCCE.** The competency exercise allows the student to demonstrate proficiency in patient selection, treatment planning, diagnostic work-up, impression making, surveying and designing, and establishment of functional occlusal relationships, laboratory work authorization, and delivery of the prosthesis. The exercise must be completed in maximum of five (5) appointments.

Eligibility requirements for participation on the FCCE:
*Successful completion of all FCCE SCE prerequisites.

Grades Calculated for all Prosthodontics procedures:

- **A = 4.0**  =  (Excellent performance without faculty assistance)
- **B+ =3.5**  =  (Good performance with without faculty assistance)
- **B = 3.0**  =  (Acceptable performance without faculty assistance)
- **C+ =2.5**  =  (Acceptable performance requiring faculty assistance)
- **C = 2.0**  =  (Minimally acceptable requiring faculty assistance)
- **F = 0-1.0**  =  (Major infractions or clinically unacceptable performance requiring correction by the faculty)

Grades are calculated based on the quantity and quality of clinical
performance. The accumulative Specific Clinical Experiences (SCE) will be multiplied by the quality points achieved based on the above scale. This will equal the “Relative Grade Points” (RGP) to be used for the final grade tabulation.

**Junior Year:**

RGP Points:
- 40 and above = A
- 30-39 = B+
- 20-29 = B
- 10-19 = C+
- 1-9 = C
- 0 = F

Examples:

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>Prosthodontics SCE’s</th>
<th>Average Grade for Prosthodontics Procedures</th>
<th>RGP’s</th>
<th>Final Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. John Doe</td>
<td>10</td>
<td>4.0</td>
<td>40</td>
<td>A</td>
</tr>
<tr>
<td>2. Jane Doe</td>
<td>6</td>
<td>3.5</td>
<td>21</td>
<td>B</td>
</tr>
<tr>
<td>3. Clyde Doe</td>
<td>1</td>
<td>3.0</td>
<td>3</td>
<td>C</td>
</tr>
</tbody>
</table>

**Senior Year:**

RGP Points:
- 80 and above = A
- 70-79 = B+
- 60-69 = B
- 50-59 = C+
- 40-49 = C
- 0-39 = F

Examples:

<table>
<thead>
<tr>
<th>Student Name:</th>
<th>Prosthodontics SCE’s</th>
<th>Average Grade for Prosthodontics Procedures</th>
<th>RGP’s</th>
<th>Final Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. John Doe</td>
<td>20</td>
<td>4.0</td>
<td>80</td>
<td>A</td>
</tr>
<tr>
<td>2. Jane Doe</td>
<td>20</td>
<td>3.5</td>
<td>70</td>
<td>B+</td>
</tr>
<tr>
<td>3. Clyde Doe</td>
<td>20</td>
<td>3.0</td>
<td>60</td>
<td>B</td>
</tr>
<tr>
<td>4. Mary Jane</td>
<td>20</td>
<td>2.5</td>
<td>50</td>
<td>C+</td>
</tr>
<tr>
<td>5. Grace Mary</td>
<td>20</td>
<td>2.0</td>
<td>40</td>
<td>C</td>
</tr>
<tr>
<td>6. Tom Thumb</td>
<td>30</td>
<td>2.0</td>
<td>60</td>
<td>B</td>
</tr>
</tbody>
</table>
N. IMMEDIATE DENTURES

An immediate denture can only be constructed under the supervision and guidance of an instructor who supervises each step in the fabrication of the prosthesis. The instructor must determine the feasibility of the case based on its complexity and the capabilities of the predoctoral student.

1. Ideally, immediate dentures in the Prosthodontic clinic should be limited to the maxillary arch with extraction of only remaining anterior teeth (#5-12).
2. Immediate denture appointment for surgery/placement will not be scheduled for an afternoon or for Fridays.
3. Students are allowed to fabricate an immediate denture after having successfully completed at least one conventional denture.

O. Gold Denture Teeth (at patient’s request)

Procedure for ordering gold or open-faced gold denture teeth:

1. The student must select the appropriate acrylic teeth using the Classic Mould Guide.
2. The patient must decide which denture tooth that they desire to be replaced with a gold or opened-faced gold crown. The student doctor will secure the Masel order catalog from the Restorative Dentistry Office and present the various designs to the patient.

3. After the patient selects the tooth and the design, the student must measure the cervical-incisal and the mesio-distal width. **Faculty must note on the grade sheet that this procedure in an FCCE.**th of the desired tooth (excluding the collar).

4. When the measurements have been obtained, the student must select the appropriate gold tooth using the selection guide in the Masel catalog.

5. The student must fill out a requisition for the appropriate gold tooth and secure the faculty signature.

6. Students must take the requisition to the business office for payment of fees for gold teeth and approval stamp on the requisition.

7. Approved requisitions are turned in to the Restorative Dentistry Dispensary Clerk who will place the order.
P. Clinical Policy for Cleaning Complete and Partial Dentures

This protocol sets a standard of care for the patient that result in greater oral health and longevity of their appliances:

Patients should have their dentures and partials inspected cleaned and polished on each visit to the student clinics:

1. Disinfect for two minutes with diluted sodium hypochlorite solution (1:10 solution) obtained from the dispensary.
2. Clean in an ultrasonic cleaner to remove debris and calculus.
3. Polish with clean pumice and acrylic polishing agent.
4. Rinse with water and mouthwash.
5. Return cleansed and polished prosthesis to the patient.

Q. Progress Notes – Chronological Record for Removable Prosthodontics

(EXAMPLE 1)

Subjective Information

S – This 62 year old African American Female presents with a Perio release and completed restorative operative dentistry procedures. Her chief complaint remains, “I want upper and lower partials.”

Objective Information

O – Vital Signs
BP - 122/84
Pulse - 70

– The intraoral exam reveals the following teeth present
Upper Arch – 4, 5, 8, 9, 12 13
Lower Arch – 20, 21, 22, 23, 24, 25, 26, 27, 28, 29

– Radiographic confirmation of existing dentition with sufficient bone to adequately support cast framework removable partial dentures.

Assessment

A – The patient’s existing dentition needs to be restored with both aesthetic and functional capabilities with maxillary and mandibular cast framework removable partial dentures.
Plan

P – After completing the assessment

**Visit #1** – Upper and lower stock trays are selected for use in making initial preliminary alginate impressions.

– NV (Next Visit)
  Facebow Transfer with stabilized record bases to mount preliminary casts and to establish vertical dimension of the partially edentulous casts.

(EXAMPLE 2)

Fixed Prosthodontics Clinic SOAP Note

**Initial examination completed in one appointment.**

**Subjective Information**

S – Patient presented to the Prosthodontic Clinic with a chief complaint of “I need a crown.” According to the patient, Tooth #3 fractured on June 6, 2012, while eating. The tooth is asymptomatic.

**Objective Information**

O – Vital signs: BP 120/80, Pulse 76, Respiration 20. Intraoral examination revealed a large fractured MODBL amalgam on tooth #3. The extraoral examination revealed no significant findings. Radiographic findings consisted of multiple restorations, and recurrent decay on the mesial and distal surfaces of tooth #3.

**Assessment**

A – The patient is in need of restorative treatment for the restoration of tooth #3.

**Plan**

P – Medical and Dental Histories were reviewed. Intra and extraoral examinations were completed. The treatment process was discussed and the patient gave consent to begin treatment. Maxillary and mandibular alginate impressions were made, facebow registration was taken and an interocclusal record was completed. NV: PROS for core build-up and crown preparations.
Outside referrals for Dental Implants are to be directed to Implant Center for Initial Implant consultation:

- Letter from the referring dentist stating the reason for the consult.
- Copy of current radiographs from referring dentist. If no radiographs are available new radiographs will be taken by the assigned GPR resident.
- GPR resident will communicate with the restoring dentist and give a list of implant brands that are in usage at the school, and will ask the referring dentist to fill out the implant preference form and the surgical guide request.
- GPR resident will restore these cases in case the referring dentist opts not to restore the implant.

**Implant Consultation RESTORATIVE (faculty/Implant Center)**

- The resident will present the patient to the faculty
- The resident will assist the patient with the Informed Consent Form
- The student doctor/resident will complete the Restorative Implant Consultation Form in AXIUM
  - Explain treatment options for the replacement of the missing tooth/teeth
  - Explain the advantages and disadvantages of dental implants
  - Explain the dental implant process (restorative phase and surgical phase)
  - Discuss the need for interim restorations
  - Discuss the dental implant fees
  - The resident will complete a series of intraoral photographs and upload into Axium
  - The resident will complete a facebow registration and interocclusal record (if not present)
  - The student doctor/resident will add the surgical implant consult to the treatment plan and schedule the patient in Oral Surgery or Periodontics Clinic for an implant consult.
  - The resident is responsible for mounting the properly trimmed diagnostic cast and completing the desired diagnostic wax-up, PRIOR to the surgical consultation

**Implant Consultation SURGICAL (faculty/Implant Center)**

- The resident will present the patient to the faculty/Implant Center
  - Mounted diagnostic cast with diagnostic wax-up
  - Intraoral photographs
  - Radiographs
  - Patient
- The resident will assist the patient with the Informed Consent Form
- The resident will complete the Surgical Implant Consultation Form in AXIUM
- Discuss the patient’s bone quality and quantity (IS BONE GRAFTING REQUIRED)
• Discuss in detail the surgical phase (patient selection- prognosis)

• The resident will add additional radiographs to the treatment plan (if needed) and schedule the patient in Radiology Clinic for the desired radiograph.

• Decision to perform CBCT (Cone beam CT) will be made by the surgeon depending on the need since not all cases require CBCT.
  o Radiology Clinic will take Cone Beam CT
  o Radiology Clinic will upload the report in Axium
  o Radiology Clinic will inform (via email) the student doctor/ resident/Implant Center the report is ready for viewing in Axium

**Non-Patient Treatment (faculty/Implant Center)**

• Complex cases will be discussed with the treating and referring doctors prior to any patient treatment

• The resident will complete a detailed implant work-up
  o Ensure all implant components are ordered and present (surgical/restorative)

• The resident will fabricate the per-surgical appliance prior to surgery
  o Surgical Guide(s) (allow two weeks for fabrication)
  o Interim prosthesis (limited)

• The resident will schedule the patients for surgery implant placement

**Dental Implant Placement (faculty/Implant Center)**

• The resident will prepare the patient for surgery

• The resident/faculty/Implant Center will assist with the placement or will place the dental implant

• The resident will complete post-op instructions, post-op radiographs and schedule follow-up appointments

• **IF THE OUTSIDE DENTIST IS RESTORING THE DENTAL IMPLANT** The resident must evaluate the patient prior to restoration release (3-6months after implant placement)

• **IF THE OUTSIDE DENTIST IS RESTORING THE DENTAL IMPLANT** (Implant Maintenance WILL CONSIST OF A 1YEAR FOLLOW UP ONLY)

**Dental Implant Restoration in school of Dentistry (faculty/Implant Center)**

• The resident will present the case to the faculty/Implant Center

• The resident ensure all required restorative components are present

• The resident will schedule the patient for implant restoration
• The resident/faculty/Implant Center will assist with the restoration or will restore the dental implant restoration
• The resident will complete post-op instructions, post-op radiographs and schedule follow-up appointments

**Dental Implant Maintenance (faculty/Implant Center)**
• The will be responsible for the regular 6month recalls

• The resident/faculty/Implant Center will follow-up with the patient
  o 24 hours after restoration insertion
  o 6 months after restoration insertion
  o 1 year after restoration insertion (OUTSIDE RESTORATION)
  o Every two years thereafter
ORAL DIAGNOSTIC SCIENCE (IF PATIENT CALLS UNDERGRADUATE CLINIC)

GENERAL PRACTICE RESIDENCY (IF PATIENT CALLS OMS OR GPR)

- The student doctor/resident will complete Initial Oral Screening
- Patient will be assigned to student doctor/resident

TREATMENT PLANNING

- The student doctor/resident will complete the treatment plan
- The treatment plan must include an IMPLANT CONSULTATION APPOINTMENT (all questions will be answered during the implant consult)
- The IMPLANT CONSULTATION APPOINTMENT will occur after Operative Dentistry is complete, but before Orthodontics, Fixed and Removable Prosthodontics begins
  - Phase 2 Preventive Care/Endodontics
  - Phase 3 Operative Dentistry
  - IMPLANT CONSULTATION APPOINTMENT
  - Phase 4 Orthodontics
  - Phase 5 Fixed Prosthodontics/Removable Prosthodontics
- The student doctor/resident will make maxillary and mandibular alginate impressions
- The student doctor/resident will create properly trimmed diagnostic cast
- The student doctor/resident will complete the consultation form in AXIUM

IMPLANT CONSULTATION RESTORATIVE (FACULTY/IMPLANT CENTER)

- The student doctor/resident will present the patient to the faculty
- The student doctor/resident will assist the patient with the Informed Consent Form
- The student doctor/resident will complete the Restorative Implant Consultation Form in AXIUM
- Explain treatment options for the replacement of the missing tooth/teeth
- Explain the advantages and disadvantages of dental implants
- Explain the dental implant process (restorative phase and surgical phase)
- Discuss the need for interim restorations
- Discuss the dental implant fees
- The student doctor/resident will complete a series of intraoral photographs and upload into Axium
- The student doctor/resident will complete a facebow registration and interocclusal record (if not present)
- The student doctor/resident will add the surgical implant consult to the treatment plan and schedule the patient in Oral Surgery or Periodontics Clinic for an implant consult.
• The student doctor/resident is responsible for mounting the properly trimmed diagnostic cast and completing the desired diagnostic wax-up, PRIOR to the surgical consultation

Implant Consultation SURGICAL (faculty/Implant Center)
• The student doctor/resident will present the patient to the faculty/Implant Center
  o Mounted diagnostic cast with diagnostic wax-up
  o Intraoral photographs
  o Radiographs
  o Patient
• The student doctor/resident will assist the patient with the Informed Consent Form
• The student doctor/resident will complete the Surgical Implant Consultation Form in AXIUM
• Discuss the patient’s bone quality and quantity (IS BONE GRAFTING REQUIRED)
• Discuss in detail the surgical phase (patient selection- prognosis)
• The student doctor/resident will add additional radiographs to the treatment plan (if needed) and schedule the patient in Radiology Clinic for the desired radiograph.
• Decision to perform CBCT (Cone beam CT) will be made by the surgeon depending on the need since not all cases require CBCT.
  o Radiology Clinic will take Cone Beam CT
  o Radiology Clinic will upload the report in Axium
  o Radiology Clinic will inform (via email) the student doctor/ resident/Implant Center the report is ready for viewing in Axium

Non-Patient Treatment (faculty/Implant Center)
• Complex cases will be discussed with the treating and referring doctors prior to any patient treatment
• The student doctor/resident will complete a detailed implant work-up
  o Ensure all implant components are ordered and present (surgical/restorative)
• The student doctor/resident will fabricate the per-surgical appliance prior to surgery
  o Surgical Guide(s) (allow two weeks for fabrication)
  o Interim prosthesis (limited)
• The student doctor/resident will schedule the patients for surgery implant placement

Dental Implant Placement (faculty/Implant Center)
• The student doctor/resident will prepare the patient for surgery
• The student doctor/resident/faculty/Implant Center will assist with the placement or will place the dental implant
• The student doctor/resident will complete post-op instructions, post-op radiographs and schedule follow-up appointments

**Dental Implant Restoration (faculty/Implant Center)**
• The student doctor/resident will present the case to the faculty/Implant Center
• The student doctor/resident ensure all required restorative components are present
• The student doctor/resident will schedule the patient for implant restoration
• The student doctor/resident/faculty/Implant Center will assist with the restoration or will restore the dental implant restoration
• The student doctor/resident will complete post-op instructions, post-op radiographs and schedule follow-up appointments

**Dental Implant Maintenance (faculty/Implant Center)**
• The student doctor/resident will be responsible for the regular 6-month recalls
• The faculty/Implant Center will follow-up with the patient
  o 24 hours after restoration insertion
  o 6 months after restoration insertion
  o 1 year after restoration insertion
  o Every two years thereafter
DEPARTMENT OF ORAL DIAGNOSTIC SCIENCES
DEPARTMENT OF ORAL DIAGNOSTIC SCIENCES

ORAL DIAGNOSTIC SCIENCES CLINIC

I. INTRODUCTION

The Oral Diagnostic Sciences Clinic is the point of first clinical contact between the patient and Meharry Medical College School of Dentistry. The ODS Clinic is where the following occur:

- The patient’s suitability for treatment at the School of Dentistry is determined
- The patient’s health is evaluated
- Radiographs are taken and evaluated
- The comprehensive examination is completed and all findings are recorded

The concept of comprehensive patient care forms the foundation for all clinical treatment within the School of Dentistry. To ensure consistency and continuity in patient care; the steps above are completed in ODS and a screening form is completed. Patients are then placed into a SOD patient pool where they are then equally distributed to students. Patients are assigned to students by the PSR Coordinator based on the student’s clinical experience needs. This assigned student is now responsible to take that patient through the treatment planning phase to complete the patient’s comprehensive oral evaluation and develop the sequenced, approved treatment plan and then provide the patient’s care.

A Comprehensive Oral Evaluation or Limited Evaluation must be completed on all patients, with the approval of a sequenced treatment plan by The Department of Restorative Dentistry faculty prior to the commencement of treatment in any other clinic.

II. STANDARDS OF CARE

A. Diagnosis

1. Each patient treated at the School of Dentistry will have a thorough initial evaluation and documentation of the patient’s current health status including vital signs, any current medications, and relative risk for specific infections, previous medical conditions, and history of surgical procedures.

2. The patient will be referred for a written medical consultation if a medical condition is identified which may influence future dental care, and additional information from the patient’s health care provider may assist in treatment planning.
3. Each patient treated at the School of Dentistry will have initial and regular intraoral and extraoral cancer screening examinations.

4. Appropriate diagnostic aides will be utilized during the initial patient examination, including, but not limited to radiographs, periodontal probing, and percussion and palpation examination.

5. Existing intraoral and extraoral clinical and radiographic conditions will be recorded in the patient’s record.

B. Treatment Planning (done by The Department of Restorative Dentistry)

1. A written treatment plan will include a phased description of the proposed care to be provided for the patient. The treatment plan will be written in the proper sequence, individualized to the patient’s needs.

2. Treatment planning will be based upon a diagnostic summary and reflect attention to the relevant medical and dental conditions.

3. The patient will be advised of appropriate alternative treatment approaches.

4. The detailed criteria for treatment planning, as listed in the Clinic Manual, shall apply.

5. Informed consent must be obtained from the patient/guardian prior to initiating any treatment. The patient, attending student, and faculty member approving the treatment plan will sign the treatment plan form.

6. Patient consent on the treatment plan will not imply patient financial obligation until specific treatments are initiated. The patient must verbally agree to the previously planned and consented treatment before it is initiated; the record shall reflect, at each appointment, that informed consent was obtained.

C. See diagram of ODS Patient Flow Process:
Recruited Patient’s Treatment Flow and Coding in ODS and the Treatment Planning Clinic

**Critical Start Step!! #1**
Student informs the PSR Coordinator that the patient has been recruited prior to

**Patient "Recruited" by Student Dentist to the SOD for Comp Care**
Patient appointed to ODS

**Day #1 or #2 of Patient’s ODS Appointment with the Recruiting Student Dentist in ODS**
Day #1 Patient arrives for SOD Orientation

- Recruiting Student Dentist is responsible for treating the patient for that day. *If the care is not completed that day, the student will return to complete the patient’s care in ODS. Every effort should be made to complete care in Day #1.*

**Treatment**
- Patient Assessment and Data Collection
- Faculty Approval
- Complete Patient Screening Form
- Faculty Approves Patient Screening Form (PSF)
- Decision for Pt. to go to:
  - Pre-doctoral clinic
  - Post-doctoral clinic
  - Private Practice
- PSF turned in to ODS Administrative Assistant the day of appointment
- ODS Administrator Assistant to turn the PSF in to the PSR Coordinator at the end of every clinic session
- Codes that can be used for this day:
  - 0150.9 - Comp Care exam
  - D0330 - Pano
  - D0274.9 - 4BXW
  - D0210 - FMX

**Critical Step!! #2**
If the patient’s care exceeds the “recruiting student’s” level of competency

**SOD (PSR Coordinator)**
- Patient is assigned to a student more senior by the PSR Coordinator based on the student’s clinical experience needs.
- An effort is made to allow the recruiting student dentist to perform those procedures for which they are competent.
- Both student’s and the assigned patient now make an appointment in the Treatment Planning Clinic
- If this is not possible the patient is then referred to the post-doctoral clinics (GPR/OMFS)
- At all times the care of the patient supersedes the student’s clinical experience needs.

**Day #2 or #3 Treatment Planning Clinic Dept. of Restorative Sciences**
- Completion of the patient’s comprehensive oral evaluation and develop the sequenced, approved TX. Plan
- The more senior student will ultimately be responsible for the patient’s comprehensive care.
- Codes that can be used for this day:
  - 0150
  - D0210.9
  - D0330.9
  - D0274.9
New and Returning Comprehensive Care Patient’s Treatment Flow and Coding in ODS and the Treatment Planning Clinic

Day #1 or #2 of Patient’s ODS Appointment
D3/D4 Students rotate via ODS
Day 1 Patient arrives for SOD Orientation
• D3/D4 Students are responsible for treating the patient for that day only, however the patient is officially assigned to the ODS clinic. If the care is not completed that day, the student will return to complete the patient’s care in ODS.
• Every effort should be made to complete care in Day #1.

Patient calls the SOD
Patient appointed to ODS

Day #2 or #3 Treatment Planning Clinic
Dept. of Restorative Sciences
• Completion of the patient’s comprehensive oral evaluation and develop the sequenced, approved TX. Plan
• Codes that can be used for this day
  • 0150
  • D0210.9
  • D0330.9
  • D0274.9

Patient Pool
Pre-doctoral clinic

SOD Patient Pool
(PSR Coordinator)
• Patient assigned to a student by the PSR Coordinator based on student’s clinical experience needs.
• Student and the assigned patient now make an appointment in the Treatment Planning Clinic

Treatment
• Patient Assessment and Data Collection
• Faculty Approval
• Complete Patient Screening Form
• Faculty Approves Patient Screening Form (PSF)
• Decision for Pt. to go to:
  • Pre-doctoral clinic
  • Post-doctoral clinic
  • Private Practice

• PSF turned in to ODS Administrative Assistant the day of appointment
• ODS Administrator Assistant to turn the PSF in to the PSR Coordinator at the end of every clinic session
• Patient now enters the SOD Patient Pool

• Codes that can be used for this day:
  • 0150 - Comp Care exam
  • D0330 - Pano
  • D0274.9 - 4BWX
  • D0210 - FMX
Emergency Patient Treated in ODS and Now Interested in Comprehensive Care, Patient’s Treatment Flow and Coding in ODS and the Treatment Planning Clinic

Day #1 or #2 of Patient’s ODS Appointment
D3/D4 Students rotate via ODS
Day 1 Patient arrives for SOD Orientation

- D3/D4 Students are responsible for treating the patient for that day only, however the patient is officially assigned to the ODS clinic. *If the care is not completed that day, the student will return to complete the patient’s care in ODS.*
- *Every effort should be made to complete care.*

- Treatment
  - Patient Assessment and Data Collection
  - Faculty Approval
  - Complete Patient Screening Form
  - Faculty Approves Patient Screening Form (PSF)
  - Decision for Pt. to go to:
    - Pre-doctoral clinic
    - Post-doctoral clinic
    - Private Practice

- PSF turned in to ODS Administrative Assistant the day of appointment

- ODS Administrator Assistant to turn the PSF in to the PSR Coordinator at the end of every clinic session
- Patient now enters the SOD Patient Pool

- Codes that can be used for this day:
  - 0150.9 - Comp Care exam
  - D0330 - Pano
  - D0274.9 - 4BWX
  - D0210 - FMX

Patient calls the SOD for an emergency
Patient appointed to the Emergency Clinic and

Patient calls the SOD for Comp Care
Patient appointed to ODS

Patient Pool
Pre-doctoral

Day #2 or #3 Treatment Planning Clinic Dept. of Restorative Sciences

- Completion of the patient’s comprehensive oral evaluation and develop the sequenced, approved TX. Plan
- *Codes that can be used for this day*
  - 0150
  - D0210.9
  - D0330.9
  - D0274.9
III. EMERGENCY DENTAL TREATMENT

A. The Chief Complaint and Patient Expectations

One of the first considerations made by the dental student when evaluating a new patient is the patient’s reason for coming to the dentist, the “chief complaint”. The student should always consider the possibility that a patient may require or expect immediate treatment for a problem before continuing with the Comprehensive Oral Evaluation.

B. Emergencies

These patients will be treated in the undergraduate emergency student clinic or referred as necessary to the Oral Surgery Clinic or the General Practice Residency Clinic.

D. Urgent Problems

In contrast, an urgent problem does not require immediate attention for health reasons, but is a problem the patient, and sometimes the dentist, thinks should be attended to “now” or “soon”. Examples include mild to moderate pain without active infection, asymptomatic broken teeth, lost restorations, and other purely esthetic problems. Treatment of urgent problems can, theoretically, be postponed without causing the patient unnecessary pain or the risk of systemic illness. Depending on the need, this patient could be referred to the General Practice Residency Clinic for immediate treatment, or could continue with the Comprehensive Oral Evaluation with the urgent need listed first in the treatment sequence.

E. Patient Assessment

Key questions that may be asked to determine the severity of the problem include the following:

- Does the problem disturb your sleeping, eating, working, concentrating, or other daily activities? (A true emergency disrupts the patient’s activities or quality of life.)
- How long has this problem been bothering you? (A true emergency has rarely been severe for more than a few hours to 2 days.)
- Have you taken any pain medication? Was the medication effective? (Analgesics do not relieve the pain of a true emergency.)

Additional considerations which would indicate immediate referral to the Oral Surgery Clinic:

- Patients with a fever greater than 101.5° by oral measurement.
- Uncontrollable hemorrhage.
- Maxillofacial trauma with lacerations/fractures.
• Facial swelling associated with nonrestorable teeth.

Making the distinction between an emergency and an urgent problem is important to the clinician and to the patient to ensure that no true patient emergency or concern goes unattended. On another level, the practitioner must recognize that the distinction may become irrelevant in the mind of a distraught, anxious patient.

IV. MEDICAL CONSIDERATIONS

A. Medical Consultation Request Form

1. Many patients seen at the School of Dentistry have significant past and present medical conditions and additional information or instructions are often required from the patient’s healthcare provider before treatment plan modifications can be made or a determination can be made if the patient can be treated at the dental school.

2. At the first appointment the patient’s past and present health history, current medications, vital signs, surgeries and hospitalizations are reviewed. A determination is made if a medical consultation is required.

3. The Medical Consult Request Form worksheet is completed and will then be typed by the ODS administrative assistant and returned for signature by the instructor and patient.

4. The form is sent with the patient to his/her health care provider.

5. When the form is returned, the patient’s record is obtained and the student and instructor review the consultation response and determine modifications, if any to the patient’s treatment plan. These treatment modifications as well as the medical alerts will be entered in the Medical Alerts section of the Alerts Tab of the Electronic Health Record in axiUm. See the ODS Clinic/axiUm Manual for details on how to accomplish this.

6. A copy of the Medical Consult Request Form worksheet follows this page.
B. School of Dentistry
C. Medical Consultation

Request Form

<table>
<thead>
<tr>
<th>Today’s Date:</th>
<th>Patient Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of MD:</td>
<td>Patient SS#:</td>
</tr>
<tr>
<td>MD Address:</td>
<td>Faculty DOB:</td>
</tr>
<tr>
<td>MD Phone:</td>
<td>Signature:</td>
</tr>
<tr>
<td>MD Fax:</td>
<td>Student Name:</td>
</tr>
</tbody>
</table>

- This patient’s reported medical condition makes it necessary for us to obtain written information and patient management directives from you.
- We must receive your written response on your letterhead before dental treatment can begin.
- Please do not fax or mail medical records.
- You may fax your reply to (615) 327-6067, ATTN: Mr. Donald Odom.

During the dental treatment this patient is likely to undergo, we normally expect:

<table>
<thead>
<tr>
<th>BLEEDING:</th>
<th>minimal</th>
<th>moderate</th>
<th>substantial</th>
</tr>
</thead>
<tbody>
<tr>
<td>STRESS:</td>
<td>minimal</td>
<td>moderate</td>
<td>substantial</td>
</tr>
</tbody>
</table>

**Hypertension**

At the dental exam on _________ this patient’s blood pressure was ______. The MMC School of Dentistry will not provide any dental treatment if the BP is above 180/105; will perform examination services only when the BP is between 165/95 < 180/105; and will provide most dental care services if the BP is below 165/95. Please evaluate this patient for appropriate medical intervention. We will follow our treatment guidelines unless we receive a written release from you indicating it is safe to treat this patient.

**Cardiovascular Disease:**

- **Angina:** Please indicate the frequency of angina episodes and whether or not this condition is stable. Also comment on the ability of this patient to undergo dental procedures with the indicated amount of stress.
- **MI:** Please indicate the date and severity of the myocardial infarct and comment on the ability of this patient to undergo the dental procedures with the indicated amount of stress. We generally wait 6 months post-MI before providing elective dental care services, unless you approve a shorter waiting period.
- **Cerebral Vascular Accident, TIA’s.** Please indicate the location of the cerebral event and the extent of functional impairment. Also comment on his/her ability to undergo the dental procedures with the indicated amount of stress.
- **Cardiac Arrhythmia:** Please indicate the type of arrhythmia and adequacy of control. We generally administer 2% lidocaine with 1:100,000 epinephrine for effective anesthesia, and will use no more than 2 cartridges which is equivalent to 0.036 mg epinephrine. Does this patient’s health status preclude the use of this anesthetic?

**Antibiotic Prophylaxis**

The documented increases in antibiotic-resistant microorganisms and allergic reactions in persons taking antibiotics necessitate the conservative use of antibiotics. Our goal at the MMC School of Dentistry is to prevent the unnecessary administration of antibiotics prior to dental treatment while providing antibiotic prophylaxis in those patients who are most at risk. Enclosed is a reference that lists cardiac and other medical conditions as well as various dental procedures for which antibiotic prophylaxis is and is not recommended. AHA and AAOS (American Academy of Orthopedic Surgeons) approved antibiotic regimens are included as well as other management recommendations. Please reference this information as you respond to the following questions.

- **Low to Moderate Risk Cardiac Condition:** This patient reports a history of the following cardiac condition for which the American Heart Association **no longer** recommends antibiotic prophylaxis: ______ This patient states that you recommend continued antibiotic prophylaxis prior to dental treatment. If this is the case, we request that you coordinate prescribing the antibiotics through your office. We have attached a summary of the 2007 AHA Guidelines for Prevention of Infective Endocarditis for your review.
- **Other Systemic Condition(s):** This patient reports a history of ______ Please verify and/or clarify this condition and indicate whether or not antibiotic prophylaxis is needed prior to dental treatment associated with significant bleeding or bacteremia. If yes, we will prescribe antibiotic prophylaxis according to the 2007 AHA Guidelines. (See attached) If you recommend an antibiotic regimen inconsistent with these guidelines, please coordinate the prescribing through your office.
Artificial Joint: This patient reports a history of artificial joint placement more than two years ago and no other risks for hematogenous prosthetic joint infection as defined by the American Academy/Association of Orthopedic Surgeons. The patient states that continued antibiotic prophylaxis has been recommended that appears to be inconsistent with the current (1997) AAOS Guidelines. Please advise if there are special considerations that might affect our decision on whether or not to prescribe prophylactic antibiotics. If you recommend an antibiotic regimen inconsistent with these guidelines, please coordinate the prescribing through your office.

Respiratory Disease:
☐ Asthma To prevent an acute asthmatic attack during the provision of dental treatment, we request your comments regarding the severity and frequency of this patient’s asthmatic attacks and any medications to avoid and/or dental management considerations to adopt for this patient.
☐ Tuberculosis: Please indicate if this patient has active sputum-positive tuberculosis (Primary Progressive TB). If yes, we will be unable to provide dental services until a physician’s written notification is received indicating that the TB has been successfully treated and the patient is no longer infectious.
☐ Chronic Obstructive Pulmonary Disease: Please indicate the severity of the COPD and his/her risk for respiratory depression during dental treatment. Also comment on whether or not this patient can withstand dental treatment at the stress level indicated.

Diabetes
This patient reports a history of ☐ IDDM, ☐ NIDDM which ☐ may compromise, ☐ has compromised his/her oral health and increase(d) the susceptibility to periodontal disease, oral infections, and/or delayed wound healing. To optimize our management of this patient, please comment on the medications prescribed, how well the diabetes is controlled, recent blood glucose levels and HbA1c, and renal status. If he/she is poorly controlled and susceptible to infection, antibiotic prophylaxis prior to invasive dental treatment may be indicated—please advise.

Renal Disease
☐ End-Stage Renal Disease: This patient’s history of ESRD raises concerns regarding appropriate dental management. Please indicate the presence or absence and the severity of the following conditions associated with ESRD: 1) Hematologic disorders, the potential to bleed excessively, and recent BP, PT, INR, PTT values; 2) Hypertension; 3) Anemia; 4) Nephrotoxic drugs to avoid; and 5) the patient’s susceptibility to infection.
☐ Hemodialysis: Since hemodialysis increases the patient’s exposure risk to hepatitis B, C, and HIV, please indicate if he/she is in an active or carrier state for hepatitis, or infected with HIV. The literature suggests that hemodialysis patients are at low risk of developing infective endarteritis or endocarditis secondary to dental treatment-induced oral bacteremia (assuming no other risk factors exist). Do you recommend antibiotic prophylaxis prior to dental treatment where significant bleeding is anticipated? If yes, we will premedicate as per the 2007 AHA Guidelines.

Liver Disease
This patient describes a history of ☐ heavy alcohol consumption, ☐ some form of liver damage/disease: ____. Is there evidence of cirrhosis and other related problems such as deficient coagulation factors (II, VII, IX, X); thrombocytopenia, anemia, and leukocytosis? What hepatotoxic drugs should be avoided? Is the patient susceptible to excessive bleeding associated with invasive dental care? Can he/she receive care at this time?

Psychiatric Problems:
This patient describes a history of ☐ Depression ☐ Bipolar Disorder, ☐ Schizophrenia, or ☐ Other Psychiatric Disorder: ____. How severe is this condition and how well is the patient’s psychiatric problem managed? Since most antipsychotic drugs cause dry mouth and are associated with other oral health problems, antipsychotics with minimal anticholinergic or parafunctional side effects are desirable.

Allergies/Concerns regarding Medications:
☐ Allergy: This patient reports an allergy or side effect to: ____ and describes the following symptom(s): ____. Please verify the presence or absence of this problem, and provide any patient management recommendations. If this is a drug allergy, please suggest an alternative medication appropriate for this patient.
☐ Local Anesthetic Use: The School of Dentistry routinely uses 2% lidocaine with 1:100,000 epinephrine as local anesthetic. Does this patient’s health status preclude the use of this anesthetic? Please advise.

Seizures
☐ Please indicate the type, frequency, and precipitating factors of this patient’s seizures as well as the current degree of seizure control. Also comment on the ability of this patient to undergo dental procedures with the indicated amount of stress.

Other Medical Problems:
Pregnancy. This patient indicates that she is in her First, Second, Third trimester of pregnancy. She now has urgent non-urgent dental needs. Elective, non-urgent dental treatment is reserved for the 2nd trimester or after pregnancy. We generally administer 2% lidocaine with 1:100,000 epinephrine for effective anesthesia and take limited radiographs using appropriate lead apron shielding. If you have any concerns, please advise. What oral analgesics and antibiotics would you recommend be prescribed to this patient if necessary?

Immunocompromised: Corticosteroids, Chemotherapy, Autoimmune disease, HIV, Organ Transplant. Other Because ___ increases this patient’s susceptibility to infections, do you recommend antibiotic prophylaxis prior to invasive dental treatment likely to cause significant bleeding/oral bacteremia? What other management recommendations do you have?

Radiation: Because of concerns for the development of osteoradionecrosis and its complications associated with future oral surgical procedures, please indicate the location, total radiation dosage, and any evidence of major salivary gland damage. Any patient management suggestions to avoid osteoradionecrosis are welcome.

Corticosteroid Use: This patient reports a history of long-term, short-term systemic corticosteroid use. Other than major oral surgical procedures (bony impacted extractions, bone resections, oral cancer surgery, etc.), few dental procedures warrant supplemental steroid use before, during, or after the operative period. In the event of invasive oral surgical procedures, steroid supplementation may be indicated to prevent an adrenal crisis in individuals with adrenal insufficiency. Do you recommend this patient increase his/her corticosteroid dosage before such dental appointments? If so, by what amount? Please coordinate any changes in corticosteroid dosage through your office.

Hypothyroidism/Hyperthyroidism: Is this patient’s thyroid function within normal limits? Questionable Medical History: When reviewing this patient’s medical history, we identified one or more uncertainties/inconsistencies. Please provide information regarding this patient’s medical history and comment on his/her ability to withstand the indicated stress and bleeding.

Drug Addiction: Please advise on the stint of usage/treatment ________________, . The School of Dentistry routinely uses 2% lidocaine with 1:100,000 epinephrine as local anesthetic. Does this patient’s health status preclude the use of this anesthetic? What other management recommendations do you have? Please advise.

Other: ________________.

Anticoagulant/Antithrombotic/Antiplatelet Medications:

Aspirin/Plavix/NSAID: This patient reports a history of daily aspirin/Plavix or NSAID use and will undergo oral surgical procedures that are likely to cause moderate to substantial bleeding. Please indicate the three most recent BT values and test dates. Depending on the BT values, it may be prudent to have the patient reduce or discontinue this medication 7-10 days prior to the oral surgical procedures. Please advise.
RELEASE OF RECORDS CONSENT

I, _____, hereby consent to the release of my medical records or any information regarding my health status to Meharry Medical College, School of Dentistry.

_________________________________________  __________________________
Patient’s Signature                                      Date

******************************************************************************
************
Date Sent: 8/12/2013  ☐ With patient  ☐ Faxed - By Init: _____  Date
Received: __________

Telephone Consultation:

Contact Person: ___________________________  Title: ___________________________
________________________________________

Student: ___________________________  Instructor: ___________________________
Antibiotic Prophylaxis Prior To Dental Care: A Guide for Physicians & Dentists

**D. Prevention of Infective Endocarditis Associated with Dental Care – 2007 AHA Recommendations**

<table>
<thead>
<tr>
<th>Cardiac Conditions and Dental Procedures for which Antibiotic Prophylaxis is Recommended</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiac Conditions Associated with the Highest Risk of Adverse Outcome from Endocarditis:</strong></td>
</tr>
<tr>
<td>1. Prosthetic cardiac valves, including bioprosthetic valves.</td>
</tr>
<tr>
<td>2. Previous infective endocarditis.</td>
</tr>
<tr>
<td>3. Congenital heart disease (CHD)*</td>
</tr>
<tr>
<td>- Completely repaired cyanotic CHD, including palliative shunts and conduits</td>
</tr>
<tr>
<td>- Completely repaired congenital heart defect with prosthetic material or device, whether placed by surgery or by catheter intervention, during the first six months after the procedure**</td>
</tr>
<tr>
<td>- Repaired CHD with residual defects at the site or adjacent to the site of a prosthetic patch or prosthetic device (which inhibit endothelialization)</td>
</tr>
<tr>
<td>- Cardiac transplantation recipients who develop cardiac valvulopathy</td>
</tr>
</tbody>
</table>

* Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD
** Prophylaxis is recommended because endothelialization of prosthetic material occurs within 6 months after the procedure

<table>
<thead>
<tr>
<th>Dental Procedures for which Antibiotic Prophylaxis is Recommended:</th>
</tr>
</thead>
<tbody>
<tr>
<td>All dental procedures that involve manipulation of gingival tissue or the periapical region of the teeth or perforation of the oral mucosa</td>
</tr>
</tbody>
</table>

The following procedures and events **do not need** prophylaxis |
- Routine anesthetic injections through non-infected tissue |
- Taking dental radiographs |
- Placement of removable prosthetic or orthodontic appliances |
- Adjustment of orthodontic appliances |
- Placement of orthodontic brackets |
- Shedding of deciduous teeth |
- Bleeding from trauma to the lips or oral mucosa

<table>
<thead>
<tr>
<th>Prophylactic Regimens for the Prevention of Infective Endocarditis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>E. Antibiotic Regimen Type</strong></td>
</tr>
<tr>
<td><strong>Standard Regimen</strong></td>
</tr>
<tr>
<td><strong>Oral</strong></td>
</tr>
<tr>
<td><strong>F. Adult Dosage</strong></td>
</tr>
<tr>
<td><strong>G. Amoxicillin</strong></td>
</tr>
<tr>
<td>2.0 g PO 1 hour before the procedure</td>
</tr>
<tr>
<td><strong>Child Dosage</strong> (Do not exceed adult dose)</td>
</tr>
<tr>
<td><strong>H. Amoxicillin</strong></td>
</tr>
<tr>
<td>50 mg/kg PO 1 hour before the procedure</td>
</tr>
<tr>
<td><strong>I. Standard Regimen</strong></td>
</tr>
<tr>
<td><strong>J. Unable to Take Oral Medications</strong></td>
</tr>
<tr>
<td><strong>K. Allergy to Penicillins</strong></td>
</tr>
<tr>
<td>Avoid Cephalosporins such as Cephalexin, Cefadroxil, or Cefazolin to those with a history of immediate-type hypersensitivity reactions to penicillins (urticaria, angioedema, anaphylaxis)</td>
</tr>
<tr>
<td><strong>L. Clindamycin</strong></td>
</tr>
<tr>
<td>600 mg PO 1 hour before the procedure</td>
</tr>
<tr>
<td><strong>M. Clindamycin</strong></td>
</tr>
<tr>
<td>20mg/kg PO 1 hour before the procedure</td>
</tr>
<tr>
<td><strong>Cephalexin or Cefadroxil</strong></td>
</tr>
<tr>
<td>50 mg/kg PO 1 hour before the procedure</td>
</tr>
<tr>
<td><strong>Azithromycin or Clarithromycin</strong></td>
</tr>
<tr>
<td>15 mg/kg PO 1 hour before the procedure. Do not prescribe to pregnant women.</td>
</tr>
</tbody>
</table>

| **N. Allergy to Penicillins** |
| **O. Unable to Take Oral Medications** |
| **Clindamycin 600 mg IM or IV** |
| **Cefazolin 1.0 grams IM or IV** |
| Either drug within 30 minutes of the procedure |
| **Clindamycin 20 mg/kg IM or IV** |
| **Cefazolin 25 mg/kg IM or IV** |
| Either drug within 30 minutes of the procedure |
Dental Management Considerations to Prevent Infective Endocarditis or Hematogenous Prosthetic Joint Infections in At-Risk Individuals

2. Gentle oral rinsing with antiseptic mouth rinse such as chlorhexidine hydrochloride & povidone iodine for 30 seconds prior to dental care.
3. Schedule appointments for procedures requiring antibiotic prophylaxis (ABX) 9 to 14 days apart.
4. If appointments for procedures requiring ABX are scheduled less than 9 days apart or a patient is currently on a regimen antibiotic for other reasons, use an alternate antibiotic.
5. A combination of procedures should be planned for a dental appointment in which the patient is prophylaxed.
6. When significant unanticipated bleeding occurs, administer ABX within 2 hours following the procedure.
7. Encourage full/partial denture wearers to have regular periodic oral exams to evaluate fit of dentures and return to their provider if discomfort develops.


Patients at Potential Risk of Hematogenous Prosthetic Joint Infections (HPJI)

Note: Antibiotic prophylaxis is not indicated for patients with pins, plates and/or screws

<table>
<thead>
<tr>
<th>Immunocompromised/Immunosuppressed Patients</th>
<th>Other Medical Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Inflammatory Arthropathies: rheumatoid arthritis, systemic lupus erythematosus, etc.</td>
<td>1. All patients during the first 2 years after prosthetic joint placement</td>
</tr>
<tr>
<td>2. Disease, Drug, or Radiation-Induced Immunosuppression.</td>
<td>2. Insulin-dependent (Type 1) diabetes</td>
</tr>
<tr>
<td></td>
<td>3. Previous prosthetic joint infections.</td>
</tr>
<tr>
<td></td>
<td>4. Malnourishment</td>
</tr>
<tr>
<td></td>
<td>5. Hemophilia</td>
</tr>
</tbody>
</table>

Incidence stratification of Bacteremic Dental Procedures

Higher Incidence – Antibiotic Prophylaxis Recommended

- Dental extractions
- Periodontal procedures including surgery, subgingival placement of antibiotic fibers/strips, scaling and root planing, probing, recall maintenance
- Dental implant placement and replantation of avulsed teeth
- Endodontic (root canal) instrumentation or surgery beyond the apex
- Initial placement of orthodontic bands but not brackets
- Intraligamentary and intraosseous local anesthetic injections
- Prophylactic cleaning of teeth or implants where bleeding is anticipated

Lower Incidence – Antibiotic Prophylaxis NOT Recommended

- Restorative dentistry (operative and prosthodontic) with/without retraction cord
- Local anesthetic injections (nonintraligametary and nonintraosseous)
- Intracanal endodontic treatment; post-placement and buildup
- Placement of rubber dam
- Postoperative suture removal
- Placement of removable Prosthodontic/orthodontic appliances
- Taking of oral impressions or oral radiographs
- Fluoride treatments
- Orthodontic appliance adjustment

P. Prophylactic Regimens for the Prevention of HPJI:

Q. Antibiotic Regimen Type

<table>
<thead>
<tr>
<th>R. Adult Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Regimen</td>
</tr>
<tr>
<td>Cephallexin, Cephradine, or Amoxicillin 2.0 g PO 1 hour before procedure</td>
</tr>
</tbody>
</table>
| Standard Regimen
  Unable to Take Oral Medication |
| Cefazolin 1.0 grams IM or IV 1 hour before the procedure |
| Ampicillin 2.0 grams IM or IV 1 hour before the procedure |
| Allergy to Penicillins |
| Clindamycin 600 mg PO 1 hour before the procedure |
| Allergy to Penicillins
  Unable to Take Oral Medications |
| Clindamycin 600 mg IM or IV 1 hour before the procedure |
Other Systemic Conditions Warranting Antibiotic Prophylaxis (ABX) Consideration When Invasive Oral Surgical Procedures with Significant Bleeding are Planned

- **Vascular Graphs**—Consider ABX if the graph was placed < six months.4
- **Cardiac Stents**—Consider ABX within 2-4 weeks of placement only.4
- **CABG**—Consider ABX just during the immediate postoperative period (first few weeks).
- **Renal Hemodialysis with Arteriovenous Shunts**—2-9% of patients receiving hemodialysis develop IE; 10-18% of cases are caused by microbes from the oral cavity. Premedicate if underlying cardiac risk factors associated with IE are present; otherwise consult physician regarding ABX.4,5
- **In-dwelling Catheters near the Right Side of the Heart**.
- **Ventriculoatrial (VA) Shunts for Hydrocephalus**—Ventriculoperitoneal shunts do not require antibiotic prophylaxis.
- **Sickle Cell Anemia**—Consider ABX for major surgical procedures to prevent wound infection or osteomyelitis.7
- **Alcohol Liver Disease**—Consider ABX for surgical procedures only when oral infection is present.7
- **Immunocompromised Status**
  - Uncontrolled, Poorly Controlled IDDM
  - Splenectomy
  - Chronic Intravenous Drug Abusers4,7—Incidence of IE is 2-5% per year which is significantly higher than that for those with RHD or a prosthetic heart valve. Of these cases, 5-13% are due to S. viridans. while 20-40% of IV drug users on normal cardiac valves on the right side of the heart.7
  - Chemotherapy with Hickman catheter/port
  - HIV/AIDS
  - Immediate Post-Transplant Period7 (<3 months post organ transplant, urgent dental care only)

**Unique ABX Regimen to prevent bacterial peritonitis—option depends on the circumstances:**

- a) Amox 2 gm + Metronidizole 500 mg 1 hour before procedure
- b) Ampicillin 2 gm IV + Metronidizole 500 mg IV 1 hour before procedure (if unable to take oral medications)
- c) Vancomycin 1 gm IV or Imipenem 1 gm IV slowly over hour preoperatively (if allergic to penicillins)

**AHA Standard Regimen**
- Stable Graft Post-Transplant Period (>6 months) or Chronic Rejection Period7
- Chemotherapy Patients2 (if granulocyte count is <2000 cells/mm3)—Penicillin V 500 mg initial dose 1 hour before, then 16h X 3 days2
- Leukemia, Other WBC Disorders2 (if WBC < 2000 cells/mm3 or neutrophils <1000) Penicillin V 2 gm 1 hour before, 500 mg q6h X 1 week following2

**Bibliography**

4. Werner CW, Saad TF. Prophylactic Antibiotic Therapy Prior to Dental Treatment for Patients with End-Stage Renal Disease. Spec Care 19:106-11, 1999

**B. Hypertension**

Diagnosed and occult hypertension are common findings in dental school patients. Diagnosed hypertension patients often neglect to take prescribed medication(s). This is a guide in determining how these patients should be treated in the dental school.
1. **Elective Dental Procedure**

<table>
<thead>
<tr>
<th>Systolic</th>
<th>Diastolic</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;180</td>
<td>&gt;105</td>
<td>No elective dental treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recommend patient have an immediate evaluation from healthcare provider</td>
</tr>
<tr>
<td>165-180</td>
<td>95-105</td>
<td>Dental examination services only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Recommend patient see his/her physician for evaluation</td>
</tr>
<tr>
<td>&lt;165</td>
<td>&lt;95</td>
<td>Most treatment can be provided</td>
</tr>
</tbody>
</table>

If the patient’s systolic blood pressure is **165 mm Hg** or higher or diastolic is **95 mm Hg** or higher:

- Allow the patient to rest 5 minutes before retaking the BP
- Be sure you are using the appropriate size BP cuff and appropriate technique
- If the patient is on antihypertensive medication, ask if medications were taken
- Review the patient record to determine if the patient has a higher documented guidelines from physician consultation
- Retake the BP and follow the guideline in the table based on the results.

2. **Emergent Dental Procedures**

For a patient with a confirmed high blood pressure, and whose dental pain appears to be a major contributor to the hypertension, emergency dental treatment may be initiated.

<table>
<thead>
<tr>
<th>Systolic</th>
<th>Diastolic</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt;180</td>
<td>&gt;105</td>
<td>Evaluate the patient’s cardiovascular history in conjunction with evaluation of dental pain Consultation with OMFS faculty</td>
</tr>
<tr>
<td>165-180</td>
<td>95-105</td>
<td>Initiate emergency dental treatment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Monitor blood pressure every 10-15 minutes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Consider anesthesia without vasoconstrictor</td>
</tr>
</tbody>
</table>
C. Vasoconstrictors and Local Anesthetic

One of the most common concerns encountered when dental treatment for patients with hypertension or other cardiovascular disorders is being planned is the use of a vasoconstrictor in local anesthetic.

1. Benefits of Vasoconstrictors
   a. Vasoconstrictors delay systemic absorption of the solution, which
      • increases duration and depth of anesthesia and
      • decreases the chances of toxicity,
      • and provides local hemostasis, which enhances working conditions in the operative field.
   b. These properties allow for
      • enhanced quality and duration of pain control and
      • markedly facilitate the technical procedures to be performed
      • Without these advantages, the local anesthetic is of much shorter duration, and less effectiveness and
      • is absorbed more quickly, thus enhancing the possibilities of toxicity.
      • In addition, the anesthetic solution itself often has mild vasodilatory properties that can result in increased bleeding into the operative field.
   c. Therefore, the advantages of including a vasoconstrictor in the local anesthetic are obvious.

2. Potential Danger of Vasoconstrictors
   a. The potential danger in administering a local anesthetic containing epinephrine or other vasoconstrictor to a patient with hypertension or other cardiovascular disease is
      • an untoward increase in the blood pressure or
      • development of an arrhythmia.
   b. In most cases, the amount of epinephrine administered ranges from 0.018 mg to 0.036 mg (with 1 to 2 cartridges of 2% lidocaine containing 1:100,000 epinephrine).

3. Conclusions of Clinical Investigations
   a. Several clinical investigations evaluating plasma epinephrine concentrations in normotensive and hypertensive patients have concluded:
      • One and probably two cartridges of 2% lidocaine with 1:100,000 epinephrine (0.018 to 0.036 mg epinephrine) are of little clinical significance in most patients with hypertension or other cardiovascular disease;
      • The benefits far outweighs any potential disadvantages or risks.
      • Using more than this amount is associated with an increased risk for adverse hemodynamic changes and should be approached cautiously.
      • Norepinephrine and levonordefrin should not be used for patients with hypertension because of their excessive alpha1 stimulation.
• **Relative contraindication to the use of vasoconstrictors** include patients with
  - severe uncontrolled hypertension
  - refractory arrhythmias
  - recent myocardial infarction (fewer than 6 months)
  - recent stroke (fewer than 6 months)
  - unstable angina
  - recent coronary artery bypass graft (fewer than 3 months)
  - uncontrolled congestive heart failure
  - uncontrolled hyperthyroidism

Vasoconstrictors should not be used in these patients under most circumstances.

**D. Antibiotic Premedication**

a. The School of Dentistry follows the guidelines for antibiotic premedication for the prevention of endocarditis established by the American Heart Association and the American Dental Association published in April 2007.

b. The School of Dentistry follows the guidelines for antibiotic premedication for the prevention of hematogenous prosthetic joint infections established by the American Dental Association and the American Academy of Orthopedic Surgery published in 1997.

c. A summary of these recommendations follows this page.

**E. Verbal Review of the Medical History**

a. Be sure that all items have been answered and all POSITIVE answers should be discussed with the patient.

b. Enough information must be elicited from the patient to determine one of the following:

1. The condition **Will** affect the patient
2. The condition **Will Not** affect the patient
3. Additional information is required from the patient’s health care provider (a consultation)

  c. **If the item is a SYMPTOM** (e.g., bruise easily, jaundice, shortness of breath), clarify by asking the following questions:

    1. You checked that you have or have had _________________. What can you tell me about that?
    2. Is this currently or was this in the past? If past, state date or age of patient at occurrence.
    3. Duration? Becoming better, worse?
    4. Is this symptom related to anything in particular?
    5. Has a physician been consulted? If so, what was the diagnosis?
d. If the item is a DISEASE, clarify by asking the following questions:

1. When did you have _______________?
2. Are you currently being treated for this disease? If so what type of treatment?
3. Is this disease currently controlled?
4. Do you currently have any problems related to this disease?

e. If a patient states an ALLERGY, obtain the following information:

5. When did you have an allergic reaction to __________?
6. What happened – what type of reaction did you have?
   i. Medication allergies – patients often state an allergy when it is really a negative reaction to the medication (i.e., gastrointestinal effects – upset stomach, gas, diarrhea) as opposed to a possibly life-threatening reaction (rash, hives, difficulty breathing, throat “closed up”, swelling).

f. Local anesthetic allergy – patients often say that they have an allergy because they fainted when they had a local anesthetic reaction. This is not an allergy; this is a psychogenic reaction. If a patient appears, according to the questionnaire to have NO medical problems, verify that fact; ask about:

   **Bleeding**  Have you ever had a problem with bleeding?
   How long does it take a cut to stop bleeding?

   **Exercise**  What kind of work do you do?
   What kind of exercise do you do? For how long? How often?
   Can you climb one flight of stairs or walk two blocks at a normal pace without becoming out of breath?

   **Medications**  Are you taking any kind of over-the-counter or prescription medications, herbal or nutritional supplements?

   **Allergies**  Do you have any allergies to medications, latex or any metals?

   **Doctor**  Have you seen a doctor or other professional in the past year?

V. ODS PATIENT TREATMENT PROCESS FOR THE COMPREHENSIVE ORAL EVALUATION

A. The patient contacts the school for an appointment to be seen
   - A student dentist recruits a potential patient
   - Through one of the School of Dentistry’s outreach programs
B. The front desk personnel presents the potential patient with information about treatment at the dental school and makes an appointment for the ODS Clinic (for adults 18 years and older).

C. On the day of treatment, the patient arrives 15 – 30 minutes early and signs in. The patient then completes the Patient Information form and the Dental History/Medical History form (Meharry Treatment Record Pages 1 and 6).

D. The registration desk personnel register and checks in each patient in the axiUm scheduler.

E. The student notes that the patient has checked in and prepares the assigned cubicle.

F. After completion of the forms, the patient is registered and the patient’s dental insurance is verified, if applicable.

G. The patient digitally signs the School of Dentistry Consent for Treatment form.

H. The patient pays sixty dollars ($60) to the cashier for the services to be rendered for the day and attends the new patient dental clinics orientation.

I. The student asks for permission from the ODS instructor to seat the patient.

J. The assigned dental student meets the patient, obtains the patient’s record and walks the patient to the ODS Clinic.

K. After seating the patient, the student first reviews the chief complaint to determine if an emergent problem is present or if the patient has an urgent need and expects treatment at this appointment. If either of these are the case, the student discusses the issue with an ODS instructor and the patient is offered immediate treatment in the General Practice Residency Clinic and the opportunity to make another appointment in the ODS Clinic for the Comprehensive Oral Evaluation.

L. After determining that the chief complaint is of a non-emergent/non-urgent nature, the student reviews the dental history, medical history and medications with the patient and takes the patient’s vital signs. If there are serious concerns regarding the patient’s medical conditions, the student reviews them with an ODS instructor at this time.

M. The student completes the intraoral and extraoral soft tissue examination and records the findings.

N. The student finds an open computer and opens the patient’s Electronic Health Record (EHR) in axiUm. The student uses Lexi-Comp’s Drug Information Handbook for Dentistry to evaluate each of the patient’s medications for 1) pharmacologic category and possible 2) untoward effects on the patient’s oral condition or dental treatment or 3) local anesthetic/vasoconstrictor precautions. These findings should be noted in the
Meds Form tab in the patient’s EHR. If the patient is not taking any medications, herbal supplements, vitamins, type in the word, “none.”

O. The student enters the patient’s medical alerts, unexplained symptoms, patient issues, medication-caused problems, referrals, consultations, and treatment modifications in the Medical Alerts section of the Alerts tab of the patient’s EHR in axiUm.

P. The student determines which diagnostic procedures are appropriate for this patient and and develops the Diagnostic Treatment Plan in the Tx History tab of the patient’s EHR in axiUm.

Q. The student now presents the patient findings related to the chief complaint, dental and medical histories and intra/extraoral examinations to an ODS instructor. The student also informs the instructor if a medical consult request should be sent and discusses the Diagnostic Treatment Plan, including the recommended radiographs.

R. The ODS instructor approaches the patient and asks additional questions as needed and completes the intra/extraoral examination.

S. The ODS instructor signs the bottom of the Dental History/Medical History form (Meharry Treatment Record Page 6) and the bottom of the Current Medications/Extraoral and Intraoral Examination form (Meharry Treatment Record Page 7) and assigns a grade and signs Part I of the Comprehensive Oral Evaluation Student Assessment form. The instructor reviews the following parts of the patient’s EHR in axiUm: Medical Alerts, Medications and Diagnostic Treatment Plan. The medications and the Diagnostic Treatment Plan are approved and 0150 procedure code is completed and approved.

T. The student escorts the patient to the Radiology Clinic where all radiographs are exposed, processed, and evaluated prior to the patient returning to the ODS Clinic. The radiographic procedure code (0210) in the Diagnostic Treatment Plan are completed and approved by the radiology instructor or professional staff. The radiology instructor in the Radiology Clinic must also assign a grade and sign Part II of the Comprehensive Oral Evaluation Student Assessment form.

U. The student returns with the patient and presents the radiographs to the ODS instructor for evaluation of diagnostic quality and to determine if the student can proceed with the examination of the dentition and radiographic interpretation. If it is too late in the session to proceed, the student escorts the patient to the ODS Clinic Office where a Return Visit Appointment is made.

V. The student completes the examination of the dentition and radiographic interpretation, noting all findings in the patient record on the Odontogram Form (Meharry Treatment Record Page 8) under the columns for “Present Restoration” and “Pathology” and also for “Existing Prosthesis” if applicable. When finished, the student presents the radiographic and dental findings to the ODS instructor. Next, the ODS instructor
reviews the findings by examining the patient clinically.

W. When the data is correct, the student finds a free computer and first notes all missing teeth on the odontogram in the patient’s EHR.

X. Next, the student enters all treatment procedures required by the patient in the Tx History tab of the EHR.

Y. The student determines the appropriate phasing.

Z. The instructor reviews the entered treatment procedures by comparing with the existing conditions and pathology noted on the green Odontogram Form. The procedures are then sorted by phase and the sequence is then evaluated. When correct, the instructor approves the treatment plan including the Treatment Planning Procedure Code (e.g., 150-9) by marking as complete.

AA. The student prints out the approved treatment procedures and a copy and signs both copies. The instructor signs both copies. The patient will sign one form which goes in the chart. The other copy will be the patient’s copy to take with them.

BB. The student completes the School of Dentistry Informed Consent form (Meharry Treatment Record Page 10), and have the patient initial and sign the form where appropriate. The student must sign this form as the witness. If the patient has a medical consult, the patient will sign the original and a copy will be made to be placed in the chart. After all the necessary forms have been signed by the patient, the student can dismiss the patient with permission from the ODS instructor. The student will walk the patient out of the clinic.

CC. The student returns and completes the odontogram on the Odontogram form and the SOAP note for the day’s encounter on the Treatment Record (Meharry Treatment Record Page 13). Once these have been completed and submitted to the ODS instructor for review and signatures, the student will clean the cubicle. The student will not leave the ODS clinic until all forms have been completed and the instructor dismisses the student.

DD. The ODS instructor will review and sign the Odontogram form, School of Dentistry Informed Consent form, the SOAP note, assign a grade and sign for Part III of the Comprehensive Oral Evaluation Student Assessment form. The ODS instructor will also indicate the classification of the patient on the Patient Information form (Meharry Treatment Record Page 1).

EE. The chart which contains the patient record, radiographs, medical consult (if applicable), Acknowledgment of Receipt form, Insurance forms, and Assessment form are returned to the ODS Administrative Assistant who disposes of the items as follows:
1. Charts of incomplete treatment plans and completed treatment plans of recruited patients- Chartroom
2. Charts of completed treatment plans of non-recruited patients- Dr. Scales office for assignment
3. Assessment forms- Recorded by ODS Administrative Assistant and filed in student’s file

VI. PROCEDURE CODES USED IN THE ODS CLINIC

0140 Limited Evaluation (0140)

- Appropriate for a single treatment on a patient who has no other extensive needs.
  - The patient’s current physical status is ASA I or ASA II
  - No periodontal disease in that quadrant
  - No gross caries, broken or grossly defective restorations on other teeth in that quadrant
  - Single treatment =
    - FCCE – (Class II, Class III)
      ✓ Same day, next day, or possible appointment for walk-in.

Class II or Class III Patient
CODES: Limited Eval (0140)
       Pan xray (0330)
- Other Limited Treatment
  ✓ Make appointment for limited evaluation
    - a. One Endodontic treatment and semi-permanent restoration
    - b. One crown
    - c. One 3-unit bridge

CODES: Limited Eval (0140)
       1 PAX (0220)
       1 BWX (0274)
       Each Add’l (0230)

✓ Patient will be scheduled to appropriate clinic for treatment
✓ Fees for treatment will be in addition to exam and x-rays

- Use yellow packet of forms for Limited Treatment
- Limited treatment must always be in the best interest of the patient!
• **Digital Radiology Codes/Fees**
  
a. Digital Panoramic  
   Code D030  
  
b. Digital Ceph  
   Code D0340  
  
c. Cone Beam  
   Code D0360  
  
d. Intra Oral Photo  
   Code D0350  
  
e. Digital Full Mouth  
   Code D0210  
  
f. Digital 1 PA  
   Code D0220  
  
g. Digital Bitewing  
   Code D0270  
  
h. FMX  
   Code 210.9  
  
i. Bux  
   Code 0274.0  

• The **Limited Evaluation** consists of  
  o A thorough evaluation of the patient’s health and dental history  
  o A thorough evaluation of the intra and extra-oral soft tissues  
  o Radiograph(s) as indicated of the area in question  
  o Examination and charting of the tooth in question  
  o Development of limited treatment plan  

**0150.9 Comprehensive Oral Evaluation (0150.9)**  

• Used for all patients new to the School of Dentistry, except for those seen for Limited Evaluation  
• Used for patients that have been seen previously at the School of Dentistry but who need a new treatment plan  
• Comprehensive Oral Evaluation consists of  
  o A thorough evaluation of the patient’s health and dental history  
  o A thorough evaluation of the intra and extra-oral soft tissues
Medical consultations as indicated
- Radiographs
- Examination and charting of the dentition
- Identification of pathology
- Identification of treatment procedures required
- Development of integrated, sequenced treatment plan

0010 Patient cancelled appointment

0020 Patient no-showed for appointment

0170 OP F/U

0210 X-rays full set

0220 Intraoral periapical x-ray – first film

0230 Periapical x-ray each additional

0240 Occlusal x-ray

0274.9 X-ray bitewings (4 films)

0330 X-ray panoramic

VII. PARTS OF THE DIAGNOSIS AND TREATMENT PLANNING PROCEDURE

A. Patient Assessment and Data Collection

1. Chief complaint
2. Dental history
3. Vital signs
4. Health history evaluation
5. Extraoral exam
6. Intraoral exam
7. Radiographs
8. Interpretation of radiographs
9. Examination of the dentition
10. Charting of findings

B. Problem List

C. Diagnosis
D. Treatment Procedures for Each Problem

E. Phased/Sequenced Treatment Plan Developed

Phase I (Diagnosis)
- Initial Exam
- Radiographs
- Diagnosis and Treatment Planning

Phase II (Disease Control - in order of urgency)
- Periodontics
- Patient Education
- Endodontics
- Oral Surgery
- Caries Control

Phase III (Operative)
- Amalgams
- Composites
- Core Buildups

Phase IV (Orthodontics)

Phase V (Prosthodontics)
- Single Crowns
- Post & Core/Core Buildups
- Fixed Prosthodontics (3-unit bridges)
- Removable Prosthodontics (Complete & Partial Dentures)

Phase VI (Maintenance)
- Exit Exam

VIII. ODS CLINIC PROCEDURES AND PROCESSES

A. ODS Rotation & Patient Appointment Procedures

1. ODS Rotation Appointments

Junior and senior dental students in the fall and spring semester will be assigned to the ODS Clinic by the Rotation Coordinator.

“Rotation” patients are those patients that contact the dental school for a dental appointment and have not been recruited by a particular student.

The front desk personnel will schedule patients in the rotation slots as the patients call in for appointments. Please note that we cannot guarantee that a patient will
be scheduled for any particular slot or that a scheduled patient will actually appear for the appointment.

2. Recruited Patient Appointments

Junior recruited patient appointments are made with the front desk personnel. Senior recruited patient appointments and return visit appointments are made by the ODS faculty and staff. The recruiting student can make the appointment or the patient can call and make the appointment. The recruiting student MUST be the student who sees the patient in ODS unless special arrangements have been made with that student and approved by a member of the ODS faculty.

- Students may recruit patients on their own
- Students may recruit a patient they have seen on GPR or Oral Surgery rotation if the patient expresses a wish to return for comprehensive treatment at the SOD
- Students may recruit a patient through the “Adopt a Grandparent Program”

3. Walk-in Appointments

“Walk-in appointments” are on a space-available basis on the day/hour of the appointment and at the discretion of the ODS faculty scheduled to work in the ODS clinic. Patients MUST NOT be told to come in until a verified chair is available. Every effort should be made to use regularly scheduled appointments through the front desk or the ODS Administrative Assistant rather than through a “walk-in appointment”. Please see rules/regulations regarding walk-in appointments on the following page.

4. Return Visit Appointments

Perhaps 30% of all patients seen in the ODS Clinic require a second visit. This is called a “return visit appointment”. All return visit appointments will be made through the ODS Administrative Assistant.

5. Illness or Other Absence

If you find that you are unable to see a patient on short notice, (for example, because you are ill or have a death in the family), in addition to contacting your PSR and the Associate Dean of Clinical Services, you must contact the ODS Administrative Assistant (327-6360) and the Front Desk (327-6669) as soon as possible so that other arrangements can be made for your appointed patient.

If you have a recruited patient appointment, we expect that you will reschedule that appointment or find a replacement to see that patient for you.

Whether you have been assigned to an ODS Rotation, or made an appointment for a recruited patient, it is your responsibility to find a student to cover for you if you will be unable to be present for your ODS Rotation or
scheduled appointment. If you know this in advance, you and your replacement must see the ODS Administrative Assistant to make the necessary changes and fill out a rotation excuse form. Please see the following page for an example of the Rotation Excuse form.

If you are on ODS Rotation, first check axiUm to determine if a patient has been scheduled. If a patient has not been scheduled or canceled, the ODS Administrative Assistant or scheduled clinical ODS faculty must officially excuse you from your rotation session. You are then required to bring your excuse form and report to the PSR Coordinator for a new daily clinical assignment or activity immediately and inform the rotation coordinator NLT as soon as possible. Informing the PSR Coordinator ensures your clinical attendance for the day and the Rotation Coordinator is responsible for the rotation schedule and ensures that the documentation gets to the Office of Clinical Affairs.

Oral Diagnostic Sciences
Walk-In Policies

1. Please see Mr. Odom in the Department of Oral Diagnostic Sciences (ODS) if you have questions or concerns regarding walking in a patient for treatment in ODS.

2. Mr. Odom will contact you within 45 minutes to one hour after each clinic session starts to inform you if space is available for you to call or bring in your patient for treatment.

3. At 9:00 am and 1:45 pm Mr. Odom will check the appointment list against the patient walk-in and will begin contacting students who wish to walk-in their patients.

4. A rotation student whose patient has cancelled will have First Priority to bring in his or her walk-in patient to the ODS Clinic. You must arrange this with Mr. Odom or the ODS Faculty member.

5. If a student cannot reach their patient within 15 minutes, Mr. Odom will move on to the next student for walk-in.

6. The best patients to “walk-in”: 
a. Patients that can be at Meharry within 30 minutes of being called. It is best to determine in advance if space is available to walk-in for a particular session
b. Patients that can easily be completed within a shorter time period
   i. Complete denture patients (CD/CD)
   ii. Limited treatment patients

7. Excused absences

Excused absences are those absences where you have filled out a Rotation Excuse form based on the following reasons:

   a. Death
   b. Illness
   c. Licensure exam (in other states, i.e. Florida)
   d. Date change for National Board, Part II

Seeing a patient in another clinic during your scheduled appointment will constitute as an unexcused absence. A Rotation Excuse form will not be signed by any ODS faculty or staff member for this reason. A recruited patient coming in for an “emergency” will not constitute as an excused absence. If it is an “emergency”, the patient must be seen in the Emergency Clinic, by the student doctor.

You must either switch dates with a classmate or owe a rotation date before you can see a recruited patient or ask for a patient to use for FCCE, licensure exams, etc. **You have thirty (30) calendar days to make-up the missed appointment.**
8. Unexcused absences

Unexcused absences are those absences where you simply do not show up and you have not notified anyone of your absence or a need to find a substitute to see your patient. This behavior shows a lack of professionalism and concern for the wellbeing of your patient and will be treated accordingly.

If this occurs, you are required to make-up two (2) additional rotation dates before you can schedule a recruited patient. While on rotation, you must see a patient or assist another student for the entire clinic session if your patient cancels or fails to show for the scheduled appointment. You have thirty (30) calendar days to make-up the missed appointment. You must perform two additional rotation dates before scheduling a recruited patient, and you will not be given a patient to work on in other clinics. A scheduled rotation date cannot be used as a make-up date.

Please remember that it is your responsibility to insure that you are not double booking patients (with your PSR and ODS) when you are on ODS rotation. If a patient is “double booked” and you choose NOT to see the patient in ODS, that will be considered an unexcused absence.
Please note that notification of your absence to other administrative faculty or personnel is **insufficient** for purposes of the **ODS Clinic**. You MUST ALSO notify the ODS Clinic and the Front Desk at the numbers listed above so that your patient can be treated in spite of your absence. This is because the ODS Clinic often does not receive notice of your absence in time to ensure proper adjustments to patient care.

**A. Information for Patients Interested in Becoming Patients**

- Our patients receive excellent dental care!
- It will take longer.....a lot longer!
  - Generally treatment at MMC is best for patients that have more **TIME** than **MONEY**!
- Treatment is NOT free!
- The patient will need to pay for the Comprehensive Exam and Full mouth x-rays and it will take at least one 3 hour session, and probably two (possibly three!)
- The patient needs to be able to SIT for three hours
- Emergency treatment will be completed in the Emergency Clinic
- The patient must pay for treatment as it is completed

**B. The School of Dentistry “accepts” payment from only a limited number of insurance companies (this means the patient only has to pay their portion). Check with the insurance department to determine what the patient would be required to pay at the first appointment. **Patient Assignment (Subject to Change)**

1. **Recruited Patients**

Recruited patients will always be assigned to the recruiting student unless the patient’s treatment plan is determined to be too difficult. An effort will always be made to allow the recruiting student to perform those procedures for which they are competent.

2. **Rotation Patients**

Rotation patients are assigned to the ODS clinic only and not to students; students are assigned to provide care to those patients for that day only. After patients have been treated by the ODS clinic, patients are then placed into a SOD patient pool, where they are assigned to students based on student’s clinical experience needs.

**C. ODS Clinic Cubicle Set-up and Break-down**

1. **Instruments YOU are required to bring:**
   - **Big 3 – STERILIZED (BAG SYMBOL WILL BE GRAY IN COLOR)**
2. Supplies Required - Provided for you:
   - 2 x 2 gauze (2-3 pieces)
   - Cotton tip applicator
   - Air/water syringe tip
   - Miscellaneous barriers
   - Patient bib

3. **DO NOT SET UP A CUBICLE UNTIL YOUR PATIENT HAS ARRIVED!**

4. You will use School of Dentistry infection control procedures to clean the cubicle before and after you see the patient. Be sure you check around the cubicle for trash left by a previous student.

5. **DO NOT** take more than 1-2 pair of gloves; **DO NOT** place a handful of gloves in a bag and take to your cubicle. This is a waste of gloves and will count against your grade.

6. Items that go in the **RED** trash can:
   - Anything soiled by saliva or blood
     - 2 x 2 gauze
     - Cotton tip applicator
     - Air/water syringe tip
     - Miscellaneous barriers
     - Patient bib
     - Gloves

6. Items that **DO NOT** go in the **RED** trash can:
   - Anything **NOT** soiled by saliva or blood
     - Paper towels
     - Masks
     - Wipes
7. Clinic cubicles that are not cleaned properly after use will result in a decrease in your grade for that patient.

E. Initial Presentation of Patient to the ODS Instructor

“Dr. ________, my patient is a (age) year old (race) (gender) who presents with (chief complaint).”

Briefly review the POSITIVE findings from the dental history.

Review each POSITIVE finding from the medical history, including the answers to the questions you asked from the “Verbal Review of the Medical History” on page 9.

State the vital signs you obtained and note if any were abnormal.

Review each of the medications-supplements taken by the patient, state its pharmacologic category and whether there are any side effects or drug interactions of concern. (Example: The patient is taking Adderall, which is a stimulant the patient is taking for ADHD. Vasoconstrictors must be used with caution with Adderall, could cause hypertension and cardiotoxicity. No high blood pressure is seen, however.

State whether you feel a medical consult is required, and if so, why.

State only any positive findings from the extra and intraoral examinations and describe those findings in detail as well as any subjective findings from the patient and a differential diagnosis.

State the radiographs you would like to take on the patient.

IX. Progress Notes – Chronological Record of Dental Care

A. Each time you have an encounter with a patient, you must make a notation on the Chronological Record of Dental Care. In the ODS Clinic this notation is in the form of a “SOAP” note

S: Subjective information
Summary of information obtained from the patient

Patient presents with a chief complaint of....(history of chief complaint)

O: Objective information
Summary of information obtained from the examination

Vital signs
The intraoral examination revealed…….
The extraoral examination revealed…….
The radiographic findings consist of…..(carious lesions, retained root tips, multiple restorations, a soft tissue lesion located...)

A: Assessment
Summarize the type of treatment the patient is in need of

The patient is in need of restorative and/or periodontal and/or fixed prosthodontic or removable prosthodontic, etc.
or
The patient is need of radiographs and a treatment plan.

P: Plan
1. List the treatment rendered/completed at this appointment
2. State the treatment that is to occur at the next appointment

Student signature and number
Faculty signature and number

B. A SOAP note must be completed after EACH patient visit – NO exceptions.

C. The SOAP notes are the legal documentation of treatment provided to the patient; therefore:

- Do not leave blank lines in the SOAP note
- Use only black or dark blue non-erasable ink
- Do not scribble out or attempt to erase errors – instead, draw a single line through the error and initial
- All entries must be signed by the student and countersigned by the attending instructor

ODS Clinic SOAP Note
Example 1

Exam, radiographs and treatment plan completed in one appointment.

S: Patient presented to the ODS clinic with a chief complaint of “I need a check-up.”
The patient’s last visit to the dentist was in June 2001.

O: Vital signs: BP 120/75, Pulse 76, Respiration 20. Intraoral exam revealed
generalized calculus and a palatal tori. The extraoral exam revealed multiple
pigmented lesions that have not changed in size. Radiographic findings consisted of
numerous restorations, carious lesions and impacted 3rd molars.
A: The patient is in need of restorative and periodontal treatment. In addition the patient is in need of extraction of impacted 3\textsuperscript{rd} molars.

P: Medical and dental histories were reviewed, an intra and extraoral exam were completed, 14 PA and 4 BW radiographs were taken and a treatment plan was formulated and presented to patient. NV: OS for extraction of 4 impacted 3\textsuperscript{rd} molars.

\textit{Student signature and number}
\textit{Faculty signature and number}

\textbf{S.ODS Clinic SOAP Note}
\textbf{Example 2}

\textbf{Medical and dental histories reviewed only.}

S: Patient presented to the ODS clinic with a chief complaint of “I need a check-up.” Patient’s last dental visit was two years ago.

O: Vital signs: BP 145/84, Pulse 73, Respiration 15. Extraoral examination revealed a healing “cold sore” on the upper right vermillion border of the upper right lip. Intraoral examination not performed. Patient states lesion has been present for three days.

A: Patient is in need of intraoral examination, radiographs, and a treatment plan.

P: Medical and dental histories reviewed. Extra/intraoral examinations not evaluated. Patient told to return to ODS clinic in fourteen (14) days after herpetic lesion (cold sore) has healed completely. N.V. ODS for radiographs and treatment plan.

\textit{Student signature and number}
\textit{Faculty signature and number}

\textbf{ODS Clinic SOAP Note}
\textbf{Example 3}

\textbf{Medical/dental histories and intraoral and extraoral examinations only completed.}
\textbf{Medical consultation required before proceeding.}

S: Patient presented to the ODS clinic with a chief complaint of “I need dentures because all of my teeth hurt”. The patient’s last dental visit was 10 years ago. Patient complains of constantly biting right inside of cheek.
O: Vital signs: BP 190/110, Pulse 80, Respiration 16. Extraoral examination was WNL. Intraoral examination revealed a 1.0 cm pedunculated, pink nodule of the right buccal mucosa in the plane of occlusion near the right commissure of the lip.

A: The patient is in need of a medical consult, due to high blood pressure and possible history of emphysema. Clinical diagnosis of soft tissue lesion: irritation fibroma. In addition, the patient is in need of a biopsy of the lesion.

P: Medical and dental histories were reviewed and intraoral and extraoral soft tissue examinations were completed. N.V. ODS for radiographs and treatment plan, pending medical consult.

Student signature and number
Faculty signature and number

ODS Clinic SOAP Note
Example 4

Medical/dental histories and intraoral/extraoral examinations only completed. Patient reappointed for radiographs and treatment plan.

S: Patient presented to the ODS clinic with a chief complaint of “I need my teeth cleaned.” It has been 3 years since the patient has had a cleaning.

O: Vital signs: BP 135/70, Pulse 68, Respiration 18. Intraoral exam revealed palatal tori and generalized calculus. The extraoral exam was WNL.

A: The patient is in need of radiographs and a treatment plan.

P: Medical and dental histories were reviewed and an intra and extraoral exam were completed. N.V. ODS for radiographs and treatment plan.

Student signature and number
Faculty signature and number

ODS Clinic SOAP Note
Example 5

Patient returned for radiographs and treatment plan.

S: Patient presented to the ODS clinic to complete radiographic exam and treatment plan.

O: Vital signs: BP 140/90, Pulse 62, Respiration 17. Radiographic findings consisted of numerous restorations including a defective PFM crown on # 30.
A: The patient is in need of restorative and periodontal treatment.

P: 14 PA and 4 BW radiographs were taken, and a treatment plan was formulated and presented to the patient. N.V. Perio for perio exam.

ODS Clinic SOAP Note
Example 6

Dental history reviewed. Patient referred to GPR clinic for pain in tooth.

S: Patient presented to the ODS clinic with a chief complaint of “My back tooth hurts.” Patient states he has been in pain for the past few days.

O: Vital signs not recorded.

A: Patient is in need of emergency treatment in the GPR clinic. Comprehensive examination can be completed once tooth in question has been treated.

P: Dental history reviewed. Patient referred to GPR clinic for emergency treatment. Patient’s money refunded as well. N.V. ODS for comprehensive examination.

ODS Clinic SOAP Note
Example 7

Medical and dental histories reviewed. Patient referred to GPR clinic for complexity of medical history.

S: Patient presented to the ODS clinic with a chief complaint of “I need a check-up.” Patient’s last dental visit was in 2002.


A: Patient is in need of radiographs and a treatment plan.

P: Medical and dental histories were reviewed. Extra/intraoral examinations not reviewed by ODS faculty. Patient referred to GPR clinic due to extensive medical
history of constant seizures, GI feeding tube, and uncontrolled COPD. NV. GPR
for initial visit.

ODS Clinic SOAP Note
Example 8

Medical and dental histories reviewed. Patient referred to private practice due to time
constraints.

S: Patient presented to the ODS clinic with a chief complaint of “I need a crown for my
tooth in two weeks.” Patient’s last dental visit was six months ago.

O: Vital signs: BP 105/70, Pulse 70, Respiration 13. Extraoral examination revealed a
scar over the left eyebrow and popping of the left TMJ. Intraoral examination
revealed physiologic pigmentation on the maxillary and mandibular alveolar ridge.

A: Patient is in need of radiographs and a treatment plan.

P: Medical and dental histories reviewed. Extra/intraoral examinations not reviewed by
ODS faculty. Patient referred to private practice because the dental school hours did
not accommodate the patient’s schedule. Patient’s money refunded as well.
N.V. Treatment at private practice.

ODS Clinic SOAP Note
Example 9

Medical and dental histories reviewed. Extra/intraoral examinations completed.
Radiographs taken and tentative treatment plan of consults formulated.

S: Patient presented to the ODS clinic with a chief complaint of “I would like to save
my teeth.” Patient’s last visit to the dentist was twenty years ago.

O: Vital signs: BP 125/85, Pulse 60, Respiration 16. Extraoral examination revealed
multiple nevi that have not changed in size. Intraoral examination revealed palatal
tori, bilateral mandibular tori, and generalized calculus. Radiographic findings
revealed numerous missing teeth, gross decay, and extensive bone loss.

A: Patient is in need of perio and removable prosthodontic consults.
P: Medical and dental histories reviewed, extra/intraoral examinations were completed, 1 PAN and 8 PA were taken, and a tentative treatment plan was formulated and presented to the patient. A comprehensive treatment plan will be formulated after the perio and removable prosthodontics consults are performed. N.V. Perio for perio consult.

ODS Clinic SOAP Note
Example 10

Medical and dental histories reviewed. Extra/intraoral examinations completed. Radiographs taken and patient referred to GPR/Private Practice for dental treatment.

S: Patient presented to the ODS clinic with a chief complaint of “I need to fix my bridge.” Patient’s last visit to the dentist was a year ago.


A: Patient is need of prosthodontic treatment for the bridge.

P: Medical and dental histories reviewed, extra/intraoral examinations were completed, 14 PA and 4 BW were taken. A treatment plan was not formulated due to the complexity of the case at the undergraduate dental level. Patient referred to the GPR clinic for treatment. N.V. GPR for initial visit.

X. ODS CLINIC PATIENT APPOINTMENT CHECKLIST

Before seating patient
✓ Arrive before your scheduled clinic time with required sterilized instruments
✓ Determine if your scheduled patient has arrived
✓ When your patient arrives, set up assigned cubicle, NOT BEFORE!!!
✓ Collect patient from reception area
✓ Seat patient

Seat patient
✓ Determine if the patient’s chief complaint is of an emergent or urgent nature
✓ Take and record vital signs
✓ Review health history with patient
✓ Complete the extra-oral and intra-oral soft tissue examinations and record findings
✓ Determine if medical consult is required
✓ Determine the appropriate examination and radiographs to be taken
✓ Find an open computer
  • Look up patient’s medications – Enter information in the EHR in the Forms tab
  • Enter the patient’s Medical Alerts
  • Enter the patient’s Diagnostic Treatment Plan
✓ Present the patient to ODS faculty, who will approve Diagnostic Treatment Plan and Medications Form and grade Part I of the evaluation form
✓ Complete the diagnosis procedure and have it approved by the instructor

Take radiographs
✓ If there is doubt as to diagnostic acceptability of radiographs, check with ODS faculty before bringing patient back to ODS Clinic
✓ Complete the x-ray procedures and have them approved by Radiology Clinic personnel
✓ Show radiographs to ODS faculty; determine if time allows for you to finish the examination and paperwork.

Examination of dentition
✓ Completed by the Department of Restorative Dentistry during Treatment Planning

Faculty verification of findings
✓ In the Tx History tab, enter treatment procedures for each problem
✓ Determine correct sequence for procedures
✓ Complete the SOD Screening form and approval/signature by faculty, give form to ODS Administrative Assistant who will then give the form to the PSR Coordinator.

Dismiss patient
✓ Complete SOAP note
✓ Present completed workup to ODS faculty for grading and then clean your cubicle

XI. ODS CLINIC GRADING CRITERIA

ORDG 571-01 Junior Year
Evaluation Two (2) Final Clinical Competences Exam (FCCE): One (1) FCCE in ODS to be completed in the fall and one (1) FCCE in the spring semester

Grades are based on points attained by completion of the patient’s comprehensive evaluation, diagnosis and presentation to attending doctor.

These grades (points accumulation) are composed of evaluation of the health status of the patient, intraoral and extraoral examinations, radiographic survey, general documentation and the assessment of professional and behavioral evaluations. The criteria for these evaluations are found in the Axium ODS grade sheet.

At the end of the fall and spring semesters a clinical competency exam is administered (FCCE).
The grading system for Oral Diagnosis Sciences is the following:

- **A** = 200 points
- **B+** = 180 points
- **B** = 160 points
- **C** = 140 points – Minimum # of points to be promoted to Senior
- **F** = <139 points

*Each Junior Student will average 11 to 13 rotational sessions through the Oral Diagnostic Sciences clinic each semester. Also, each student will receive up to twenty (20) points for external rotational site visits with Dr. Walter Owens.

Grades are assigned at the end of the fall and spring Semesters.

**ORDG 621-01 Senior Year**

*Evaluation is based upon Competences (FCCE) and points.*

Grades are based on points attained by completion of the patient’s comprehensive evaluation, diagnosis and presentation to attending doctor. Student evaluation for completion of the Department of Oral Diagnostic Sciences expected competences is (1) completion of competencies in junior year, (2) successful completion of comprehensive diagnostic sciences FCCE, upon completion of one (1) and two (2) student will be completed with the Oral Diagnostic Sciences expected competencies.

- **A** = 100 points
- **B+** = 90 points
- **B** = 80 points
- **C** = 70 points – Minimum points to clear ODS Clinic for graduation
- **F** = <69 points

*Each Senior Student will average 7 to 8 rotational sessions through the Oral Diagnostic Sciences clinic each semester. Also, each student will receive up to twenty (20) points for external rotational site visits with Dr. Walter Owens.

**Comprehensive Oral Evaluation Student Assessment Form**

- **Five Grading Criteria = 20 possible points/patient**
  - Part I *
    1. Health Status
    2. Extra and Intraoral Examination
  - Part II *
    3. Radiographic Survey
    4. General Documentation
5. Professional and Behavioral Evaluation

* Refer to Axium ODS Grade Sheet Criteria

Each part can be evaluated and signed by a different instructor; however all criteria within a part must be evaluated by an instructor (if the initial instructor is not available).

- **Key to Scores**
  - 4.0 = Student performed exceptionally without intervention
  - 3.0 = Student performed acceptably without intervention
  - 2.0 = Student required minimal intervention from instructor
  - 1.0 = Student required significant intervention from instructor
  - 0.0 = Instructor needed to perform required tasks

  - The scores for all criteria are added together to assign the total number of points achieved for that case

*Limited Evaluation Student Assessment Form*

- **Five Grading Criteria = 20 possible points/patient**
  - Part I *
    1. Health Status
    2. Extra and Intraoral Examination
  - Part II *
    3. Radiographic Survey
    4. General Documentation
    5. Professional and Behavioral Evaluation

Each part can be evaluated and signed by a different instructor (if the initial instructor is unavailable)

- **Key to Scores**
  - 4.0 = Student performed exceptionally without intervention
  - 3.0 = Student performed acceptably without intervention
  - 2.0 = Student required minimal intervention from instructor
  - 1.0 = Student required significant intervention from instructor
  - 0.0 = Instructor needed to perform required tasks

  - The scores for all criteria are added together to assign the total number of points achieved for that case

XII. ODS Clinic Dress Code
The students will follow the School of Dentistry Dress Code, however, please note the following:

A. All students must wear only clean, neatly pressed scrubs individually identified by student’s name.

B. No white coats are to be worn in the ODS Clinic.

C. Barrier gowns are not to be worn in the ODS Clinic unless the student is specifically told to by an ODS instructor.
I. INTRODUCTION

Without question, the use of the radiographic examination in dentistry for diagnostic and treatment planning purposes is indispensable. However, important as radiographs may be, subjecting patients to ionizing radiation for diagnostic purposes must only be done after a complete review and evaluation of the dental, oral, and general medical health of the patient, and only after a thorough clinical examination. It is assumed that every radiographic exposure carries some potential risk; therefore, the risk to benefit factor must be weighed carefully with sound and logical professional judgment when determining the need, the extent, or the frequency of radiographic examinations. This judgment must include a determination of the minimum amount of radiation exposure that will produce the optimal diagnostic information with maximal radiographic quality, and should not be based upon an arbitrarily established or prescribed time frame, such as semiannually or annually.

II. IONIZING RADIATION CONTROL POLICY

The use of diagnostic x-rays is an important diagnostic tool in dentistry. In order to ensure safe use of ionizing radiation, the dental school has written institutional policies and procedures that are used under the supervision of trained personnel.

The ultimate concern with the use of diagnostic x-rays is to protect both the operator and the patient from unnecessary ionizing radiation. This goal is accomplished through the following methods:

1. **Patient selection.** Each patient must first be evaluated clinically to determine the risk versus the benefit from the exposure to ionizing radiation.
2. **Radiographic equipment.** Radiation equipment inspection is made annually and meets radiation protection standards and ADA specifications. Reports are kept on file and a copy can be provided at any time. The inspection includes established methods for calibration (radiation output and time) and proper filtration for each dental radiographic machine.
3. **Radiographic facilities.** These include a waiting room, darkroom, viewing, storage and x-ray exposure areas. These areas satisfy the shielding requirements from the Radiation Protection Committee.
4. **ALARA.** The concept of “As Low As Reasonably Achievable” is taken into consideration every time a patient is exposed to diagnostic radiation. Proper collimation by using long cones with a diameter no larger than 2.5 inches are used on each intraoral dental x-ray machine. In addition, the patient is protected by a lead apron with a thyroid collar. Direct digital receptors are used for all intraoral and extraoral exposures in the dental school. When retakes are required, training personnel will assist the student to avoid over exposing the patient. In order to
protect the operator from unnecessary radiation, it is a requirement that a minimum of six (6) feet of distance is present between the x-ray tubehead and the operator.

5. **Darkroom facilities.** The darkrooms are equipped with safelights and automatic developers. Developer solutions are changed regularly, and monitored daily. The darkroom facility will be used as a backup system to the Digital X-Rays Units.

### III. STANDARDS OF CARE

1. Selection criteria for prescribing radiographs will be based on current FDA guidelines for dental radiographic exposures (attached). Selection criteria, in part, will consider whether the patient is new or a recall patient, whether satisfactory current radiographs are available from a former dentist, the patient’s chronological age, and the risk assessment for caries, periodontal disease, and other pertinent disorders.

2. Radiographs will be prescribed only following a clinical examination. The appropriate radiographic examination shall be treatment planned and entered into the patient’s electronic health record; after the procedure is complete, the procedure will be approved by a properly licensed dental faculty member; this procedure will be required for all radiographic exposures.

3. Dental radiographs brought by the patient from outside dental practices will be evaluated by clinical faculty to determine if their quality is such that they can be used rather than exposing new radiographs.

4. A radiation control log will be completed for all exposures in all clinics.

5. The technical quality of all radiographs must be reviewed by qualified faculty or authorized professional staff, and the images must be approved in the electronic patient record, prior to the patient leaving the Radiology Clinic.

6. All radiographic exposures including remakes are to be recorded on the front of the “Patient Clinical Record” in the designated area.

7. A radiographic interpretation will be performed for all radiographs, and entered into the patient’s record.

8. In order to achieve proper diagnostic effectiveness, radiographs must have be of acceptable quality. In general, radiographs will have the proper density, contrast, and detail when viewed on clinic monitors in a semi-darkened room. Panoramic radiographs will be of adequate technical quality to demonstrate the condylar heads, the mandibular symphysis, and the teeth or alveolar ridges, with minimum distortion. Radiographs of acceptable quality must have the following characteristics:

   a. Radiographs must record the complete area of interest on the image:
i. Periapical radiographs—include the full length of the root and at least 2 mm of periapical bone

ii. Bitewings should demonstrate each posterior proximal surface at least once with maxillary premolar proximal contacts open in premolar bitewing projections and maxillary molar proximal contacts open in molar bitewing projections, with repeated projections as needed to open the mandibular contacts

iii. If a pathologic condition is evident, the entire area of interest plus an area of normal surrounding bone should show on one radiograph (periapical and/or panoramic views); if possible

b. Radiographs should have the least possible amount of distortion:
   i. Most distortion during intraoral radiography is caused by improper angulation of the x-ray beam, and not by inappropriate receptor positioning or by curved anatomical structures in the area of interest.
   ii. Pay close attention to proper receptor positioning and to proper x-ray tube alignment
   iii. Excessive distortion results in non-diagnostic images; these images should be re-taken

c. Radiographs should have optimal density and contrast to facilitate interpretation:
   i. The x-ray tube controls should remain at 70 kVp and the mA is fixed
   ii. According to Sirona, most x-ray examinations should be conducted at 0.08 seconds; however, this time should be increased for larger adults since there is more tissue present which decreases the quality of the resulting image if the time is not increased
   iii. Underexposed images are too light and too noisy (grainy or speckled appearance); these images should be retaken using increased time. When increasing the time, multiply the time used for the first image by 1.5 to determine the time for the re-take. As an example, if the 0.08 second time resulted in an underexposed image, use the following equation: 0.08 x 1.5 = 0.12 second for the retake

9. All intraoral radiographs will be appropriately mounted and placed into the patient’s electronic health record with the date of exposure.

10. A patient’s rejection of recommended radiographs may be justification for the discontinuation of dental treatment when the quality of dental care provided would be compromised.

11. The frequency of repeat exposures must be kept to a minimum. Retakes are to be approved by clinic staff—either the instructor-in-charge or the Registered Dental Assistant on duty in the Radiology Clinic.
**Note:** When repeat radiographs are requested to satisfy some special need of a department or individual clinical instructor, repeat radiographs beyond the above rule must be supervised and/or demonstrated by that department or instructor.
Date: __________________________

Patient Name: ___________________  DOB: __________________________
Student Name: ____________________  Faculty Signature __________________

Patient Classification - ASA □ 1 □ 2 □ 3 □ 4

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Consultation

□ Perio  □ Operative  □ Oral Surgery  □ Implantology
□ Endo  □ Fixed Pros  □ Removable Pros  □ Ortho

Tentative Treatment Plan

□ Fillings  □ Root Canal Tx  □ Lower Partial  □ Upper Partial  □ Perio  □ Prophy
□ Complete Denture (F/F)  □ Extractions  □ Crowns  □ Partial Denture (F/P)  □ Implants

(This information is used to appoint patients to students)

Patient Referral

□ SOD  □ General Practice Residency  □ Oral Surgery  □ Private Practice