Oral Diagnosis Clinical Guide

Faculty Supervision: Oral Diagnosis (OD) faculty are responsible for supervising data collection, and treatment planning, however, at times, OD may not be available for all clinics. In those instances, the Team Leaders should be contacted.

Data Collection: First appointment (OD-1)

- before seating the patient, review previous radiographs, chart entries and screening information

- after seating the patient, obtain a CD-5 form from the forms file at the rear of the clinic floor

- have the patient fill out the Dental History (3B)

- review the Health History (3A) and Dental History (3B) with the patient making sure to ask about positive responses; assign an ASA category (see below) based upon the medical history

- measure the patient's blood pressure and pulse and record them on the back of the Health History (3A)

- perform an oral and paraoral soft tissue examination (oral cancer screening) and record the findings in the first section of the 4A Clinical Findings form

- answer the questions on the top half of the CD-5 and then call the OD instructor before proceeding further

- the instructor will interview and examine the patient, review your preliminary findings, and then mutually decide on what data you will need to collect in order to diagnose and treatment plan your patient; the CD 5 will be completed and signed by the instructor; this will then serve as a guide for you as you complete the examination; the instructor and student should sign and date the medical and dental history forms

- if the patient has a significant medical problem such that dental treatment poses a potential risk to the patient, a medical alert red tag will need to be attached to the chart
**Red Tag Medical Alert:**

A red tag medical alert adhesive label should be applied to the edge of the back sleeve of the UKCD dental record at the earliest appointment (e.g. during data collection) if a medical condition poses a significant medical risk during dental treatment. The red label is an alert that indicates that the health care provider should review the Medical History. The label is folded over the top right edge of the back cover. No writing is placed on the label. Examples of problems which would require placement of a red tag include (but not limited to):

- Latex allergy
- Penicillin allergy
- Severe angina
- Significant cardiac arrhythmia
- Active asthma
- Patients requiring antibiotic premedication
- Patients taking coumadin
- Poorly controlled type I diabetic
- Patient with bleeding disorder

**ASA Classifications**

This classification system was originally developed by the American Society of Anesthesiologists to identify patients at risk for general anesthesia. We have adapted it for use to aid in the determination of risk in patients with various medical conditions.

ASA I: Normal healthy patient

ASA II: A patient with mild systemic disease that does not interfere with day to day activity or who has a significant health risk factor (e.g. smoking, alcohol abuse, obesity) and may or may not need medical alert tag.  
**Examples:** stage I or II hypertension, type II diabetes, heart murmur, penicillin allergy, well-controlled asthma, HIV+, mild COPD

ASA III: A patient with moderate to severe systemic disease that is not incapacitating but that may alter day to day activity; may have significant drug concerns; may require special patient care; would generally require medical alert tag.  
**Examples:** type I diabetes, uncontrolled hypertension, stable angina pectoris, previous MI, asymptomatic congestive heart failure, AIDS, severe COPD, mild hemophilia, patient taking coumadin, patient undergoing chemotherapy.
ASA IV: A patient with severe systemic disease that is a constant threat to life; definitely requires medical alert tag; patient would be treated by special patient care;
Examples: symptomatic ischemic heart disease, symptomatic heart failure, renal failure, liver failure, severe hemophilia.

Following the consultation with OD:

- complete the examination as indicated on the CD-5 and record and chart your findings on the 4A and 4B forms
- when you take the indicated radiographs, be sure that the 1B radiographic order form has been signed by a faculty member prior to taking your patient to Radiology; you will also need to take a signed radiographic technique evaluation form with you.
- if indicated, complete a request for medical consult form, and have it reviewed and signed by the instructor
- plan to dismiss the patient at least 10 minutes before the end of the clinic period
- complete a progress note using the SHAPED format (see below) and have it signed by the instructor
- have the instructor sign the Care Slip

Progress Note (SHAPED Format):

S: Section under which you are working (e.g. Oral Diagnosis) plus name of supervising faculty member (When working on a tooth or quadrant, that information should also be included here)

H: Brief update of any changes in Health status since last appointment

A: Assessment or diagnosis (for data collection, this is “To be determined”)

P: What you had Planned to do in the clinic period

E: What you actually Executed (did) during the clinic period

D: Disposition or what you plan to do the next time you see the patient; include prescriptions provided to the patient or instructions given to the patient
**Data Collection: 2nd or 3rd Appointment (OD-2)**

- check with O.D. instructor/Team Leader prior to resuming data collection on your patient
- complete all remaining data collection as indicated on the CD-5; obtain required consults only *after* all clinical and radiographic data has been obtained and recorded
- when you have finished data collection and before dismissing your patient: review data (including radiographs) with O.D. instructor/Team Leader to ensure all necessary procedures have been completed and that you are ready for treatment planning before patient is dismissed
- complete a progress note and have it signed by the instructor
- have the instructor sign the Care Slip
- schedule the patient for treatment planning at the next appointment

**Restorative Worksheets (Forms 5C and 5D) for Phase II Treatment Planning**

*Oral Diagnosis only supervises phase I treatment planning. The Team Leaders supervise phase II treatment planning as well as transfer treatment planning. These worksheets are used in preparation for treatment planning of phase II procedures. On occasion, when phase I treatment is minimal, phase I and II may be combined. In these instances, treatment planning is supervised by Oral Diagnosis.

The restorative worksheet (5C) is used when treatment planning crowns, bridges, or implant supported crowns. A set of mounted study models is required for this consult. These consults are usually completed outside of clinic time and are done by Drs. Robinson, Timmons, Selwitz, or by a Team Leader. This worksheet must be completed and signed before phase II treatment planning. If implants are planned, the “Student Clinic Implant Treatment Planning and Consent Form” (5D) must also be completed.

The worksheet is required for all 3rd year students who plan any castings. Fourth year students are required to have a consult only for (1) more than 4 single units or (2) any FPD.
PREPARATION FOR PHASE I TREATMENT PLANNING APPOINTMENT

When preparing for a phase I treatment planning appointment, use this check list to be sure you have all of the following:

1. Have your completed indicated preliminary treatment?

2. Are all chart forms completed and in proper sequence?

3. Do you have a 2A (Patient Summary)?
   - avoid being too specific
   - a brief summary that allows the instructor to understand the patient's background and problems and what treatment is needed and planned

1. Do you have a completed 3A (Health History) and recorded vital signs
   - if there are any significant problems that may cause the patient to be at risk during dental treatment, is there a red medical alert tag attached?
   - if there are any significant medical problems, have you completed a Medical Problem Worksheet for each of the problems and decided upon management modifications?
   - have you completed a Prescription Drug Worksheet for each prescription drug the patient is taking and determined if there are any potential drug interactions or side effects?
   - have you attached the returned medical consultation form to the chart if one was obtained?

2. 3B (Dental History)
   - have you identified the patient’s chief complaint or primary concern and have decided how to address it?
   - have you identified and explored all of your patient's dental complaints or problems?

3. 4A (Clinical Findings)
   - have you completed each section and addressed abnormal findings?
4. Radiographs
   - Do you have a completed radiographic interpretation report signed by Dr. Yepes?

5. 4B (Charting)
   - are restorations charted in blue?
   - are caries charted in red (including radiographic caries)?
   - are all other charting symbols in red (don't forget furcations, recession, mobility, overhangs, open contacts, etc.)?
   - are plaque and bleeding scores calculated?

6. 4H (Periodontal Diagnosis and Treatment Plan)
   - is the form signed by a perio instructor?

7. If your patient is going to have an RPD in phase 2, do you have a preliminary RPD design signed by Pros?

8. Have you obtained all necessary consults (5A), and are they signed and dated?

9. CD-12W (Red Treatment Plan Worksheet)
   - is the planned treatment sequenced by area or tooth number on worksheet?
   - is each tooth or procedure listed on a separate line; QSI codes and fees included
PHASE I TREATMENT PLANNING APPOINTMENT

Preparation:

- Treatment planning appointments are conducted in the OD (D224A) office in the back of the 2nd floor clinic, behind Ms. Farley’s office

- You are responsible for being prepared at the appointed time (check with coordinator to verify appointment time). If not, the appointment may be rescheduled.

- You are responsible for having collected and properly recorded all data indicated on the CD-5, including any preliminary treatment as well as evaluating other problems identified during data collection. (See Preparation for Phase I Treatment Planning).

- You are responsible for having appropriate instruments, supplies (including gauze 2x2’s), colored pencils and worksheets ready for use in the cubicle.

Student/Faculty Conference:

- Review radiographs and the radiographic interpretation worksheet which you have completed (recognize landmarks and normal findings and not just pathology). Review panoramic films as well as intraoral films. You should have had an appointment with Dr. Yepes to review the films

- Student will give a brief oral summary of history and clinical findings to the instructor (Patient Summary 2A)

- Review of the Medical History (3A). Discussion of Medical Problem Worksheets emphasizing the relationship to dental care. A drug worksheet should be completed for each prescription drug. Management modifications will be completed on the back of the 3A after this discussion.

- Review of the Dental History (3B) and discussion of the chief complaint. Ensure that you have addressed all indicated problems or complaints.

- Review of the Clinical Findings (4A) and discussion of pertinent findings. Make sure each section is completed.
• Review of the Clinical Charting (4B). Make sure proper symbols and colors are used. Review radiographs as you check the charting.

• Confirm information on Periodontal Consult (4H). Every patient should have this form completed and signed.

• Review all consults on the 5A form, especially as they relate to treatment recommendations.

• Review the proposed treatment plan on the red worksheet (CD-12W). Any deficiencies noted during the appointment can be listed on this worksheet.

Chairside Examination:

Faculty will:

• perform an extraoral and intraoral clinical examination.

• examine dentition for caries and restorations by asking you to report your findings and planned treatment for each tooth. This is checked against the charting.

• review the proposed treatment plan and discuss changes and sequencing; initial the corrected worksheet (CD-12W). (Unresolved problems or conflicts with treatment decisions or consults should be discussed with the Team Leader or consultants).

Student will then:

• discuss the final treatment plan with the patient, making sure they understand and accept all proposed treatment, and obtain informed consent (be sure proper sequencing is indicated on the CD-12W).

• take the patient to the business office to transfer the final plan from CD-12W worksheet to a computer generated treatment plan. Patient signs agreeing to treatment plan, payment schedule and informed consent.

• correct errors and make necessary changes in the chart as indicated and complete a progress note.

• have faculty member sign progress note and care slip.