

Provider Practice Guidelines for Dental Public Health



**Tennessee Department of Health
Community Health Services
Oral Health Services Section**

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PROVIDER PRACTICE GUIDELINES FOR DENTAL PUBLIC HEALTH

Tennessee Department of Health Oral Health Services Section

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SECTION 1

General Information for Public Health Dental Programs

**TENNESSEE DEPARTMENT OF HEALTH
COMMUNITY HEALTH SERVICES
ORAL HEALTH SERVICES SECTION**

GENERAL INFORMATION FOR PUBLIC HEALTH DENTAL CLINICS

I. Provider Practice Guidelines for Dental Public Health

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

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

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

In addition to this manual, dental staff in public health clinics in Tennessee must adhere to the guidelines and regulations presented in two companion manuals: *Tennessee Department of Health Infection Control Manual* and *Tennessee Department of Health Public Health Nursing (PHN) Protocols*. Every public health dental clinic in Tennessee should have access to the aforementioned manuals for easy reference, and they should be made available to all personnel involved in the delivery of dental care in a public health setting. Revisions, additions, and deletions will be made to these manuals when necessary to keep current with new or revised standards. The current *Provider Practice Guidelines for Dental Public Health* is available online on SharePoint [here](#).

II. ADMINISTRATIVE AND INTERDISCIPLINARY RELATIONS

Dentists, dental hygienists, and dental assistants working in dental public health clinics in Tennessee must be licensed or registered to practice dentistry, dental hygiene, or dental assisting. The Dental Practice Act, for scope of practice, for any of the above mentioned

Professionals may be found in TCA Title 63. The dentist, dental hygienist, and dental assistant are responsible for fees (registration, continuing education, license renewal) imposed by the State of Tennessee to keep all licenses or registrations current throughout the period of employment with the state. A dentist who prescribes scheduled narcotics in the course of patient treatment must have a current, unrestricted DEA number.

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

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

The normal workweek consists of 37.5 hours. Dental Staff will adhere to the TDH productivity guidance.

III. LEVELS OF DENTAL SERVICE

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

A. Level I – Emergency Dental Services

All public health dental clinics should provide for treatment of dental emergencies for adults and children. Dental emergency treatment is limited to diagnosis and treatment of an acute episode of pain, infection, swelling, hemorrhage, or trauma (i.e., relief of pain and suffering). Services delivered will be within the TDH scope of practice and provider skill set and may include extractions and/or prescription medications.

B. Level II – Primary Prevention

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

1. Oral Health Education

- a) Caries Risk Assessment
 - b) Oral hygiene instruction
 - c) Dietary counseling
 - d) Trauma prevention – bicycle helmets, seat belts/child restraints and mouth guards
 - e) Fluoride effectiveness
 - f) Oral cancer prevention
2. Prophylaxis
 3. Silver Diamine Fluoride
 4. Topical application of fluoride varnish
 5. Community water fluoridation assessment
 - a) Individual well water analysis
 - b) Adherence to current supplemental fluoride dosage schedule
 6. Pit and fissure sealants
- C. Level III – Basic Dental Services
 Services that primarily control or eliminate oral diseases (e.g., dental caries, gingivitis, and periodontitis) should be provided. Examples include:
1. Comprehensive oral diagnostic procedures
 - a) Soft Tissue Exam
 - b) Radiographic evaluation
 - c) Clinical Exam
 2. Restorative dental procedures
 3. Basic endodontic procedures
 4. Basic periodontal procedures
 5. Basic oral surgery procedures
- D. Level IV – Rehabilitative Dental Services
 Services that primarily restore oral structure may be provided. Examples include:
1. Removable prosthetic services
 2. Fixed prosthetic services
- E. Remote Supervision of Hygienists
 The following protocol is in response to the amended language of the Dental Practice Act effective July 1, 2013. TCA 63-5-109 adding subsections (15) and (16). Click [here](#) for access to TCA 63-5-109.

Definition:

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

Management:

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

- TDH annual training by the public health dentist will include didactic and on-site components utilizing evidence-based protocols, procedures and standards from the Provider Practice Guidelines for Dental Public Health and the School Based Dental Prevention Program Manual.
- TDH monitoring by the public health dentist during remote supervision activities shall include tracking locations of planned service delivery and review of reports of services provided. Phone or personal communication between the public health dentist and the dental hygienist will occur at a minimum of every 14 days.
- TDH monitoring by public health dentist of each hygienist during remote supervision will include at least semi-annually on-site visits with completion of all categories of Quality Assurance review checklist at each visit.
- A limit of three (3) TDH dental hygienists full or part time may practice under the remote supervision of a public health dentist.

Remote Supervision Practice Requirements:

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

Scope of Services:

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

IV. LEGAL ASPECTS OF TREATING MINORS

Written consent for treatment must be obtained for each patient prior to an examination or any subsequent treatment. This policy is relatively straightforward when adults present themselves for treatment at a public health facility. The question that needs to be addressed is “When can a minor authorize or consent to any medical (dental) services?”

In 1993, Patricia L. Newton, Assistant General Counsel for the Tennessee Department of Health, rendered the following legal opinion regarding authorization and consent to medical or dental care for minors. This opinion is based on *CARDWELL v. BECHTOL* (Tenn. 1987) 724 S.W. 2d 739.

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

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

V. DENTAL PATIENT RECORDS

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

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

Review Instruments for the Direct Observation of Public Health Dental Practice (refer to Section 3).

There must be a dental patient record for each individual seen in the clinic regardless of level of care being provided or payment source. **Every dental patient must have a complete, accurate, and up-to-date *Clinic Oral Evaluation and Treatment Record* (PH-0205A) and a *Health History for Dental Services* (PH-3990) or appropriate Electronic Record as part of his or her dental record.**

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

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

The policies and procedures regarding Retention and Destruction of Records are found in [CHS Policies](#). Following is the policy for retaining records:

- Medical records, to include dental, must be retained by the health department for ten (10) years following the last date of service (i.e. if the last date of service was April 25, 2007 then the record must be retained until April 25, 2017). X-rays are considered to be part of the patient record and are to be destroyed with the record.
- The medical record of a minor or person with a mental disability must be retained for the period of minority (under 18 years of age) or mental disability, plus one (1) year or ten (10) years following the last date of service, whichever is longer.
 - ❖ If a seventeen (17) year old’s last date of service was May 1, 2007 then the record must be retained until May 1, 2017.
 - ❖ If a seven (7) year old’s last date of service was May 1, 2007 then the record must be retained until May 1, 2019.
 - ❖ If a person with a mental disability continues to have a mental disability then the record cannot be disposed of, but if the person becomes better, the above guidelines will be followed.

Key identification information such as: name, gender, birth date, address, record number, and TennCare number (when applicable) must be present. A consent form or permission for treatment must be obtained from the patient, parent, or the patient’s guardian before treatment is started. **It is required that a new medical history and signed consent form be completed for each patient annually.** Update the patient’s medical history at each visit, on the

Health History of Dental Services Form (PH-3990) or in the progress note; document the date and any changes. Written informed consent **must** be obtained prior to performing any oral surgery procedure using *Informed Consent for Oral & Maxillofacial Surgery* (PH-3432). If the patient has taken an Oral Bisphosphonate drug, then the *Informed Consent for Patients Taking Oral Bisphosphonates* (PH-4035) **must** be completed as well. If the patient has no previous history of taking Oral Bisphosphonates only the *Informed Consent for Oral & Maxillofacial Surgery* (PH-3432) needs to be completed.

As our dental clinics are focusing more on adult dental care, there is the possibility of encountering more individuals on bisphosphonates and therefore more individuals at risk for Bisphosphonate Related Osteonecrosis of the Jaw (BRONJ) post- extraction. In order to provide guidance to the dental clinical staff and to provide the highest quality care to our patient population, the health history has been revised (PH-3990) and specifically asks (question 11) about medications to treat osteoporosis or osteopenia.

- A. Individuals who have taken an oral bisphosphonate for less than three years and have no clinical risk factors, no alteration or delay in the planned surgery is necessary. This includes any and all surgeries common to oral and maxillofacial surgeons and other dental providers.
 - 1. The following factors are thought to be risk factors for BRONJ:
 - 2. Corticosteroid therapy
 - a) Diabetes
 - b) Smoking
 - c) Alcohol use
 - d) Poor oral hygiene
 - e) Chemotherapeutic drugs
- B. Individuals who have taken an oral bisphosphonate for less than three (3) years and have also taken corticosteroids concomitantly, the patient should be referred to an oral surgeon for treatment.
- C. Individuals who have taken an oral bisphosphonate for more than three (3) years with or without any concomitant prednisone or other steroid medication, the patient should be referred to an oral surgeon for treatment.
- D. Individuals who are being treated with IV bisphosphonates for hypercalcemia, bone metastases and other conditions, the patient should be referred to an oral surgeon for treatment.

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

The American Society of Anesthesiologist (ASA) Physical Status (PS) Classification System is used to evaluate the patient's physical state before performing surgery. The system is not intended for use as a measure to predict operative risk, the decision to treat is up to the individual dental provider's professional judgement.

ASA Physical Status Classification:

1. ASA I – a normal healthy patient – extraction can be performed – provider’s discretion
2. ASA II – a patient with mild systemic disease – extraction can be performed – provider’s discretion
3. ASA III – a patient with severe systemic disease – patient should be referred to an oral surgeon
4. ASA IV – a patient with severe systemic disease that is a constant threat to life – patient should be referred to an oral surgeon

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

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

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

Appropriate radiographs as determined by the dentist as necessary for diagnosis or treatment. All radiographs, film and electronic images, should be labeled, dated, mounted/oriented **correctly** and maintained as part of the patient’s record. Dental radiographic images are maintained as part of the dental record until the record can be destroyed according to [CHS Policy](#). It is recommended that the type and quantity of radiographs be based on the following guidelines:

- Following the ALARA Principle (As Low as Reasonably Achievable) to minimize patient’s exposure. See table on page 5 of the [ADA's Radiographic Recommendations](#)

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

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

All CHS Policies can be found online [here](#).

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

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

Progress notes must be legible using blue or black ink. Each entry must be dated and signed (using signature on Legal Signature Page) by the provider, using proper credentials i.e. DDS,

RDH or RDA. Identifying patient information must be included on all forms. Errors must not be corrected with white out. A line should be drawn through the mistake to avoid the impression that a record may have been altered. Write CID (Correction in Documentation) immediately above the mistake, then initial and date if different from date of original entry. Documentation of progress notes should be completed directly after patient treatment; must be completed the same day of service.

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

VI. TREATMENT FACILITY

The dental public health clinic should be located in a facility that provides for adequately sized clinical operatories, adequate heating and cooling, and proper lighting to provide dental treatment in optimal conditions. It is the responsibility of the dentist to assure that the public health dental clinic is maintained in a manner that provides dental staff and patients with a clean and orderly place to work and receive dental care. The dentist is responsible for assuring that the clinic has the necessary equipment and supplies.

VII. EMERGENCY PROTOCOL AND EQUIPMENT

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

VIII. QUALITY ASSURANCE REVIEW

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

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

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

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

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

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

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

Oral Health Services tracks and monitors statewide data for all dentists providing direct patient care in public health facilities to ensure that dentist quality assurance review evaluations are completed in a timely manner.

The regional dental director has the responsibility of assuring that necessary corrective action is taken to bring the evaluated dentist into compliance with the quality assurance criteria and provider practice guidelines for public health dentistry. The template for a corrective plan of action is available in the QI Manual. Besides improving individual performance, the findings from the

quality assurance evaluations will be used to target specific areas of public health dental practice for discussion at future field staff meetings and continuing education programs.

IX. GENERAL TREATMENT INFORMATION

- A. Efforts should be made to provide pertinent and accurate information to parents and children concerning their role in the maintenance of good oral health. Each patient should be given home care instruction to include oral hygiene care and dietary information.
- B. Treatment of dental caries and major esthetic defects should be given the highest priority after relief of pain and infection. Treatment should follow a logical sequence. Normally, with minor variations, this is:
 - 1. Relief of pain and suffering
 - 2. Elimination of infection and traumatic conditions
 - 3. Caries Risk Assessment
 - 4. Caries control (Silver Diamine Fluoride applications)
 - 5. Prophylaxis, preventive procedures, and oral hygiene instruction
 - 6. Endodontic therapy
 - 7. Periodontal therapy
 - 8. Extractions
 - 9. Restoration of teeth
 - 10. Replacement of teeth
 - 11. Placement of the patient on an individualized recall schedule
- C. Preventive and restorative dentistry should be emphasized rather than extractions unless there is no alternative.
- D. Conduction block or infiltration anesthesia should be used whenever indicated during operative procedures to control pain and should always be used for extractions.
- E. A child should not be physically restrained or forced to accept treatment. If reasonable persuasion or use of inhalation conscious sedation does not result in the cooperation of the child, it is suggested that the child be referred to a pediatric dentist for treatment.
- F. Respect for and awareness of the dignity of all patients should be an integral part of all interactions between patients and dental staff.
- G. Accurate records must be kept in order to have available data on each patient's dental needs, treatment rendered, and the effectiveness of the overall program.
- H. Protective eyewear is required for all patients during treatment.

X. EMERGENCY SERVICES

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

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

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

Because of manpower, resource, and time limitations only an emergency examination and treatment of the emergency condition should be performed at the emergency visit. Patients who qualify for additional comprehensive dental care should be scheduled for dental treatment at the public health facility.

A sufficient number of appropriate radiographs should be ordered and interpreted by the dentist. A periapical radiograph of diagnostic quality (i.e., adequate area of observation and proper density, contrast, and detail) ***must*** be made prior to extracting any tooth (except in the case of primary teeth near exfoliation). A current diagnostic quality radiograph of must be made prior to extraction of any permanent tooth. If the patient rejects radiographs recommended by the dentist, written confirmation to this effect must be made on the patient's record.

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

- A. If the tooth can be restored, but time does not allow for a permanent restoration, Silver Diamine Fluoride should be applied to the area.
- B. If root canal therapy or a pulpotomy is indicated, initial endodontic treatment should be performed to relieve pain. The patient should be scheduled to return in five to seven days for continued treatment.
- C. Patients with acute conditions that negate the ability to achieve adequate local anesthesia should receive palliative treatment and scheduled for more definitive treatment when the acute conditions subside.

- D. Appropriate antibiotics and/or analgesics are dispensed or prescribed if necessary.
- E. If the emergency is complex and is beyond the ability of the dentist or outside the facility's scope of treatment, the dentist should arrange referral to other appropriate dental treatment sources.

XI. DIAGNOSTIC SERVICES

A proper diagnosis consists of the patient's state of oral health and the existence of any pathology or abnormal condition including the causes and type of pathology or condition. The primary diagnostic tools are the dental history, medical history, radiographs, clinical examination, and caries risk assessment. The dentist is responsible for obtaining adequate medical and dental histories for each patient. The medical history must be updated at each appointment and any change noted on the PH-3990. Medical **conditions** or **medications** requiring an alert must be flagged, **using appropriate sticker or an annotation made in red pen on the Health History for Dental Services and Clinic Oral Evaluation and Treatment Record to indicate medical alert.** Any condition that may affect dental treatment is to be noted on the treatment page. If there is a question or compromising condition, the patient's physician should be consulted.

TDH will follow current American Heart Association guidance concerning the need for and medications used for prophylactic coverage of dental treatment.

A thorough intraoral examination of the hard and soft tissues and extraoral examination of the head and neck must be performed on all initial care patients. An abbreviated oral and extra-oral examination must be performed on all emergency patients. Bitewing radiographs supplemented with a sufficient number of appropriate periapical images or panoramic radiographs for the proposed treatment are required prior to treating any patient. All patients should be properly shielded with a lead apron and thyroid collar when radiographs are taken. If radiographs are not indicated or refused by the patient, the reason should be recorded on the patient's record.

A treatment plan must be developed for every patient undergoing comprehensive care. Examination findings for each tooth and its defective surface(s) must be recorded on the patient record. A caries risk assessment should be provided along with the treatment plan. Caries management by caries risk assessment enables the provider to identify the cause of caries by assessing the risk factors for each individual patient.

A systematic approach to treatment by mouth quadrants should be utilized with the objectives of completing necessary dentistry in the fewest number of patient visits. For example, if treatment is needed on the lower right quadrant for a permanent molar, second primary molar and first primary molar, block anesthesia may enable the dentist to perform necessary treatment of all three teeth at one visit.

XII. PREVENTIVE SERVICES

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

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

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

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

Some patients having pit and fissure caries are indicated for sealants and, when appropriate, dental providers should place sealants over incipient lesions. Studies specifically designed to measure caries progression under small, sealed lesions have shown minimal or no caries progression. It is recommended that staff place sealants over incipient caries confined to the enamel because it is extremely effective in arresting this type of decay; it conserves tooth structure; and it is reversible. Sealants used to treat caries are referred to as therapeutic sealants.

Silver Diamine Fluoride (SDF) is applied directly to cavitated lesion for the non-surgical arrest of caries in children and adults. Published reports of randomized clinical trials consistently demonstrated very high rates of caries arrest. SDF has also demonstrated impressive caries prevention to adjoining teeth not receiving direct application of SDF. As long as the teeth are asymptomatic, it is recommended that staff place SDF as an intervention as soon as caries are detected.

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

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

Because of an increase in the milder forms of dental fluorosis associated with fluoride ingestion in excess of that necessary to prevent tooth decay, a conservative approach to fluoride supplementation should be used. If a child's primary drinking water source is a well, spring, or non-fluoridated community water system, a water sample must first be taken and analyzed to determine the fluoride content and the dosage of fluoride supplement needed, if any. TDH does not provide water sample testing.

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

XIII. RESTORATIVE SERVICES

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

All restorations should reproduce sound tooth contours.

XIV. ENDODONTIC SERVICES

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

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

XV. PERIODONTIC SERVICES

If there are oral hygiene problems, gingivitis, or periodontal disease, the dentist should inform the patient, parent, or guardian and provide the necessary treatment (full mouth periodontal charting, scaling, root planing and curettage, prophylaxis, and oral hygiene instruction), if possible. Moderate and severe periodontal disease should be referred to the periodontist.

XVI. ORAL SURGERY SERVICES

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

When any tooth is extracted, all portions of the tooth should be removed, except under circumstances where injury to the surrounding hard and/or soft tissues is likely to occur with

further attempts at retrieval. If it is necessary to leave a root tip, the patient should be informed; treatment options including referral should be discussed; and all pertinent information should be documented in the patient's record.

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

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

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

Following oral surgery, all patients must be given oral post-operative instructions in addition to written post-operative instructions. These instructions must be documented in the patient's chart as follows: Oral & Written Post-op Instructions (PH-0064) and given to patient. Thorough documentation in the dental record of the oral surgery procedure(s), complications, quantity and type of anesthetic, post-operative instructions, medication(s), and referrals must be completed by the dentist after all oral surgery.

XVII. REFERRALS

At a minimum, dental public health facilities should provide comprehensive oral diagnosis, oral disease preventive services, and routine dental treatment for children and emergency dental treatment for adults. However, it is recognized that uncooperative children will need to be referred on occasion to pediatric dentists. Also, referrals should be made for services not offered in the dental facility. All referrals for medical/dental consultation or treatment must be documented in the patient's dental record.

XVIII. PATIENT RECALL

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

XVIV. SAVE ACT

SAVE ACT stands for Systemic Alien Verification for Entitlements

Federal law effective October 12, 2012, **requires** all state agencies to use of the SAVE program to verify that *all adults 18 years and older* are either:

- US Citizens *or*
- Lawfully present in the US
- Before* receiving non-exempt services.

The SAVE Act does not apply to ‘Exempt Services’:

- Emergency Medical/Dental Care
- Disaster & Emergency Preparedness Response
- Immunizations
- Testing & Treatment of Communicable Disease (STD, TB, HIV, etc.)
- WIC
- Prenatal Care provided by the Department of Health (includes pregnancy testing)
- HUGS
- Family Planning Services
- Breast & Cervical Cancer Screening Program
- Children Special Services
- Prenatal Dental Services
- The Act applies to local health departments and regional health clinics --***but does not apply to local health departments that are also Federally Qualified Health Centers (FQHCs).***

SECTION 2

Dental Clinical Public Health Forms

**TENNESSEE DEPARTMENT OF HEALTH
COMMUNITY HEALTH SERVICES
ORAL HEALTH SERVICES SECTION**

Dental Clinical Public Health Forms and Internal Use Forms

- Health History for Dental Services (PH-3990) English on one side, Spanish on other side
- Health History for Dental Services, Spanish (PH-3990) – See note above
- “Clinic” Oral Health and Treatment Record (PH-0205A)
- Standardized Charting Examples & Instructions for Charting
- Caries Risk Assessment
- Periodontal Charting Record (PH-3970)
- Periodontal Charting Example & Instructions
- Periodontal Screening and Recording (PSR)
- Dental Examination and Operative Record (PH-0205B)
- Informed Consent for Silver Diamine Fluoride (PH-4300)
- Informed Consent for Silver Diamine Fluoride, Spanish (PH-4300S)
- Informed Consent for Oral & Maxillofacial Surgery, English (PH-3432) – This is a double sided form with English on one side, Spanish on other side
- Informed Consent for Oral & Maxillofacial Surgery, Spanish (PH-3432S) – See note above
- Patient Consent for Treatment by Dental Students (PH-4399) –English on one side, Spanish on other side
- Informed Consent for Oral Surgery in Patients Who Have Received Oral Bisphosphonate Drugs, English (PH-4035) – This is a double sided form with English on one side, Spanish on other side
- Consent for Surgery for Oral Bisphosphonates, Spanish (PH-4035S) – See note above
- What To Do After Extraction of a Tooth, English (DH-0064) – This is a double sided form with English on one side, Spanish on other side
- What To Do After Extraction of a Tooth, Spanish (DH-0064) – See note above
- Dental Encounter Form (PH-3626)
- Autoclave and Spore Test Log
- Waterline Treatment and Monitoring Form
- Clinical Competency Checklist for Dental Assistants 1
- Clinical Competency Checklist for Dental Assistants 2
- Clinical Competency Checklist for Dental Assistants 3
- Reporting Attempts to Unlawfully Obtain Controlled Substances
- Informed Consent for the Use of Nitrous Oxide Tool
- Prenatal Med Consult Tool
- Pregnancy Signage for X-Ray Areas



HEALTH HISTORY FOR DENTAL SERVICES

Fill Out In Blue Or Black Ink

Patient Name: _____
 Patient Birthdate: _____
 Patient Social Security Number (Optional): _____
 Patient Address: _____

 Patient Phone: (____) _____

Medication List:

General:

1. What is the reason for the visit today? _____
2. Have there been any changes in health in the past year? Yes No
3. Is patient under the care of a doctor? Yes No
 If yes, explain: _____
 Name of Doctor: _____
4. List all surgeries: _____

5. **Past/Current Medical History: (Circle all that apply)**
 Patient is Healthy ADHD Arthritis Artificial Joints Anemia
 Asthma Diabetes Seizures/Fainting Liver Disease/Jaundice
 Hepatitis HIV/AIDS Heart Disease High Blood Pressure
 Low Blood Pressure Tuberculosis Regular Ear Infections STDs
 Mentally Challenged Learning Disabilities Kidney/Bladder Disease
 Cancer* Other Conditions: _____
 Explain all circled: _____

 *Did patient receive chemo or radiation? Yes No
6. Has the patient ever had a serious injury to head/face/jaw? Yes No
 If yes, explain: _____
7. Has patient ever had abnormal bleeding due to injury, surgery, or having teeth pulled? Yes No
 a- Has patient received blood transfusion? Yes No
 b- Does patient have blood clotting disorders? Yes No
 If yes, explain: _____

Social History:

8. Active sports: (list name of sport or N/A) _____
9. Substance Abuse: (circle all that apply) N/A Alcohol Cocaine Meth
 Cigarettes E-Cigarettes Chewing Tobacco Synthetic Drugs
 Marijuana Pills/Medicine Other: _____
 When was the last time substance was used? _____
10. **Allergies: (Circle all that apply)**
 N/A Lidocaine Penicillin Sulfa Drugs Sedatives/Sleeping Pills
 Aspirin Iodine Codeine Latex Nickel Seasonal Allergies
 Other Medicine/Substances: _____

11. Has the patient taken any medication (Fosamax, Boniva, Actonel) for Osteoporosis or Osteopenia (Brittle Bone)? Yes No
12. a- How many sugary drinks are consumed daily? _____
 b- How much water is consumed daily? _____
13. a- How many times a day do you brush your teeth? _____
 b- How often do you floss? _____

Female Patients:

14. Are you pregnant or is there a chance you may be pregnant? Yes No
15. Are you currently on birth control? Yes No
 If yes, type of contraceptive: _____

Emergency Contact:

16. Emergency Contact: _____
 Relationship: _____
 Phone Number: (____) _____

Additional Notes: _____

STATEMENT OF CONSENT FOR HEALTH SERVICES

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

Patient or Parent/Guardian Name: (Please Print) _____
 Patient or Parent/Guardian Signature: _____ Date: _____
 Dentist Signature: _____ Date: _____

Office Use Only – Health History Update

Date: MM/DD/YY	Any Changes		Date: MM/DD/YY	Any Changes		Date: MM/DD/YY	Any Changes		Date: MM/DD/YY	Any Changes	
	Yes	No		Yes	No		Yes	No		Yes	No



Nombre del paciente: _____
 Fecha de nacimiento del paciente: _____
 Número de Seguro Social del paciente (Opcional): _____
 Dirección del paciente: _____
 Teléfono del paciente: () _____

Lista de medicamentos:

General:

- ¿Cuál es el motivo de la visita de hoy? _____
- ¿Ha habido cambios en el estado de salud el año anterior? Sí No
- ¿El paciente está bajo el cuidado de un doctor? Sí No
Si la respuesta es sí, explique: _____
Nombre del doctor: _____
- Lista de todas las cirugías: _____
- Antecedentes médicos: (Encierre en un círculo todos los que apliquen)**
El paciente es saludable Trastorno de déficit de atención c/hiperactividad
Artritis Articulaciones artificiales Anemia Asma Diabetes
Convulsiones/Desmayos Enfermedad del hígado/ictericia Hepatitis
VIH/SIDA Enfermedad del corazón Presión sanguínea elevada
Presión sanguínea baja Tuberculosis Infecciones del oído frecuentes
Enfermedades de transmisión sexual Discapacidad mental
Discapacidades del aprendizaje Enfermedades del riñón/vejiga Cáncer*
Otros padecimientos: _____
Explique lo que marcó: _____
*¿El paciente recibió quimioterapia o radiación? Sí No
- ¿Ha tenido el paciente lesiones graves en la cabeza/cara/mandíbula? Sí No
Si la respuesta es sí, explique: _____
- ¿Ha tenido el paciente un sangrado anormal debido a una lesión, cirugía o extracción dental? Sí No
a- ¿Ha recibido el paciente una transfusión de sangre? Sí No
b- ¿Tiene el paciente trastornos de la coagulación? Sí No
Si la respuesta es sí, explique: _____

Antecedentes sociales:

- Deportes activos: (lista de los deportes o indique N/A) _____
- Abuso de sustancias: (encierre en un círculo todas las que apliquen)
N/A Alcohol Cocaína Metanfetamina Cigarrillos Cigarrillos-E
Tabaco de mascar Drogas sintéticas Marihuana Pastillas/Medicina
Otros: _____
¿Cuándo usó la sustancia por última vez? _____
- Alergias: (Encierre en un círculo todos los que apliquen)**
N/A Lidocaína Penicilina Sulfas Sedantes/pastillas para dormir
Aspirina Yodo Codeína Látex Níquel Alergias por el clima
Otra medicina/sustancia: _____
- ¿Ha tomado el paciente medicinas como Fosamax, Boniva o Actonel para la osteoporosis u osteopenia (huesos quebradizos)? Sí No
- a- ¿Cuántas bebidas con azúcar consume al día? _____
b- ¿Cuánta agua consume al día? _____
- a- ¿Cuántas veces al día se cepilla los dientes? _____
b- ¿Cada cuánto usa el hilo dental? _____

Pacientes del sexo femenino:

- ¿Está embarazada o hay probabilidades de que lo esté? Sí No
- ¿Está usando anticonceptivos? Sí No
Si la respuesta es sí, tipo de anticonceptivo: _____

Contacto en caso de emergencia:

- Contacto de emergencia: _____
Parentesco: _____
Número de teléfono: () _____

Notas adicionales: _____

DECLARACIÓN DE CONSENTIMIENTO PARA SERVICIOS DE SALUD

Por este medio doy mi consentimiento a todas las visitas necesarias para que el paciente _____ reciba una evaluación oral, tratamiento dental, tratamiento de seguimiento para mantenimiento, transporte para los servicios, y para la divulgación de información de condiciones de salud a agencias oficiales y/o doctores particulares. Hasta donde sé, las preguntas anteriores sobre los antecedentes médicos se contestaron con exactitud. Se me entregó una copia del Aviso de las Prácticas de Privacidad del Departamento de Salud.

Nombre del paciente o padre/tutor (en letra de molde) _____
 Firma del paciente o padre/tutor: _____ Fecha: _____
 Firma del dentista: _____ Fecha: _____

**Solo para uso de oficina
Health History Update**

Date: MM/DD/YY	Any Changes		Date: MM/DD/YY	Any Changes		Date: MM/DD/YY	Any Changes		Date: MM/DD/YY	Any Changes	
	Yes	No		Yes	No		Yes	No		Yes	No

Name: _____

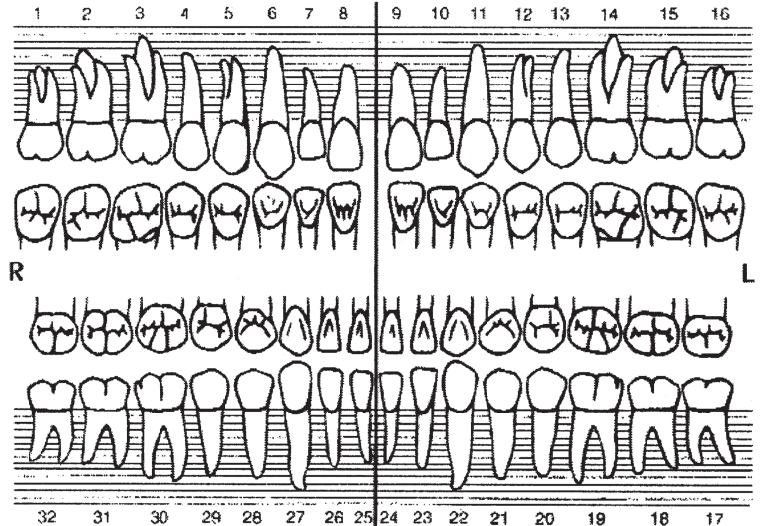
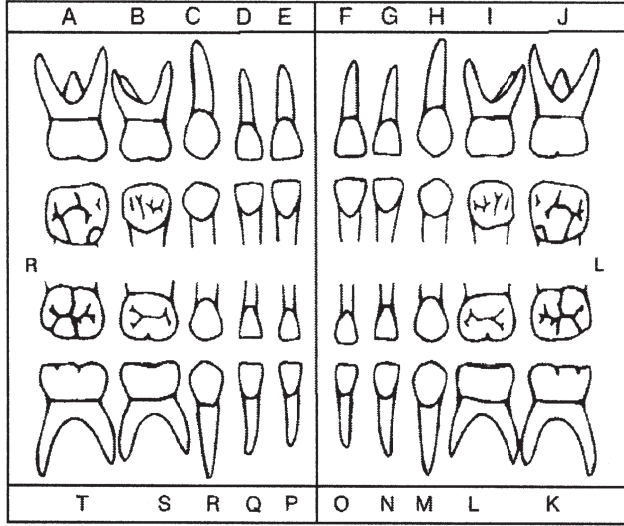
TREATMENT PLAN					
Tooth	Treatment	Tooth	Treatment	Tooth	Treatment

TREATMENT PLAN					
Tooth	Treatment	Tooth	Treatment	Tooth	Treatment

Exam Date _____

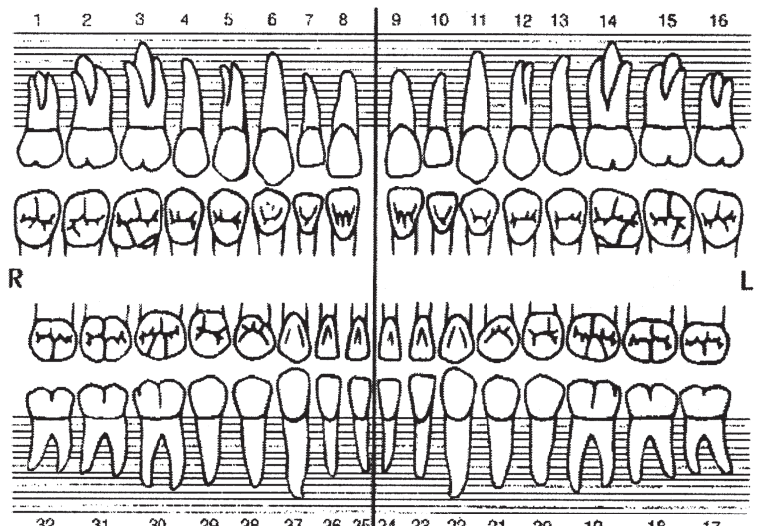
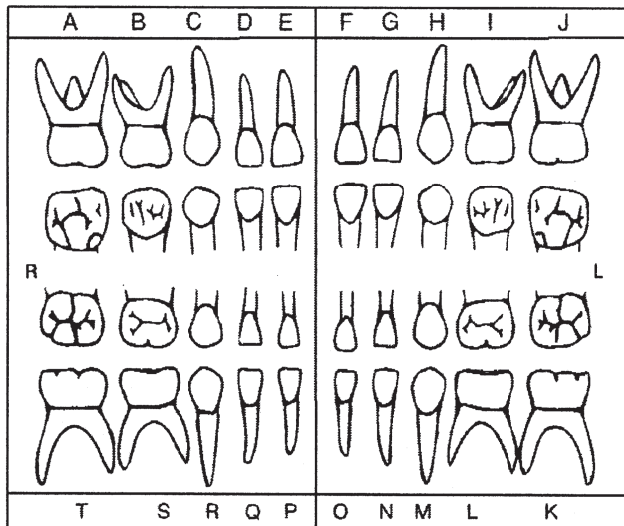
Medical Alert _____

Existing Conditions



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

Treatment Rendered





SAMPLE

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

Name:

(First) (Middle) (Last)

Affix Label

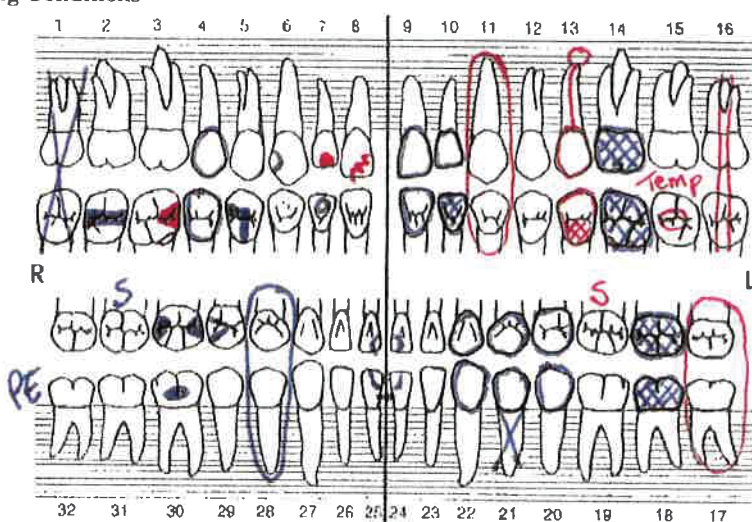
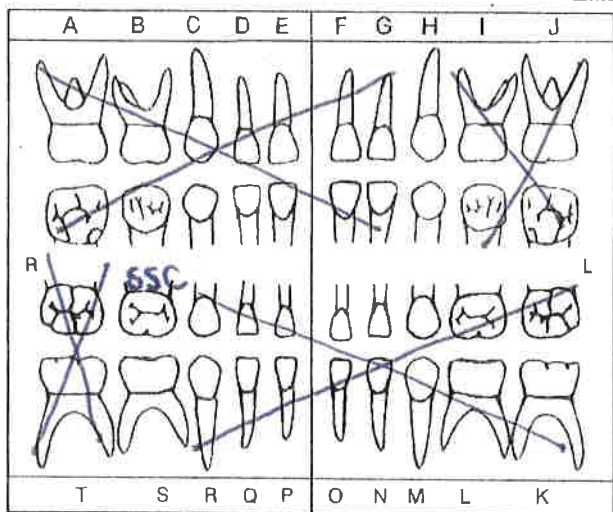
Medical Alert

Exam Date

TREATMENT PLAN

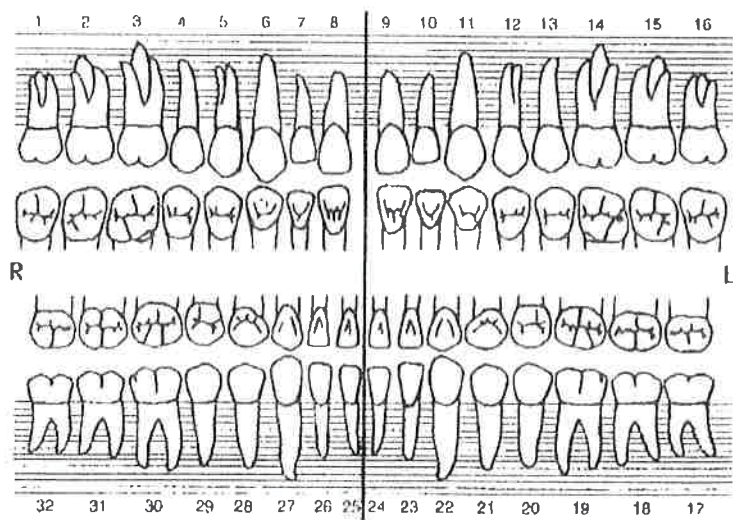
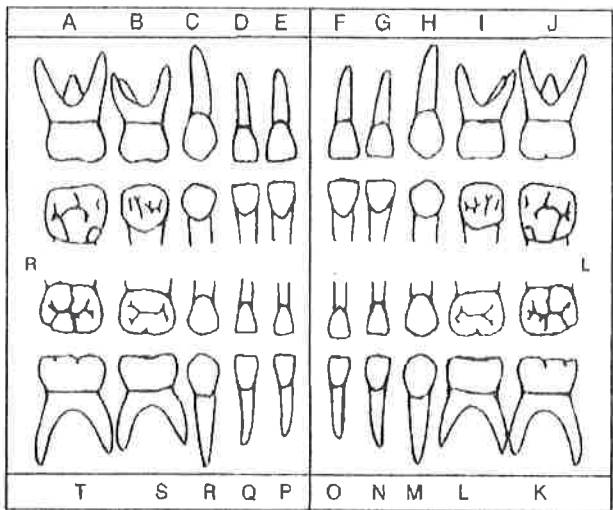
Tooth	Treatment	Tooth	Treatment	Tooth	Treatment

Existing Conditions



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

Treatment Rendered



STANDARDIZED CHARTING

Dental Charting

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

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

Descriptions:

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

Treatment needed – charted using red

Treatment complete – charted using blue

Existing conditions – charted using blue

Caries Risk Assessment Form (Age 0-6)

Patient Name:

Birth Date:

Date:

Age:

Initials:

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

Overall assessment of dental caries risk:

Low

Moderate

High

Instructions for Caregiver:

Caries Risk Assessment Form (Age 0-6)

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

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

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

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

Caries Risk Assessment Form (Age >6)

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

Overall assessment of dental caries risk: Low Moderate High

Patient Instructions:

Caries Risk Assessment Form (Age >6)

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

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

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

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Signatures

Patient, Parent or Guardian

Student

Faculty Advisor



AFFIX LABEL

Tennessee Department of Health Oral Health Services Periodontal Charting Record

Med. Alert _____

Circle Box:
Bleeding in Red
Exudate in Blue

DATES:		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
C																	
B																	
A																	
C																	
B																	
A																	
B																	
P																	
A																	
B																	
C																	
C																	
B																	
A																	
L																	
B																	
A																	
B																	
C																	
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	
A																	
B																	
C																	

MOBILITY
POCKETS
>3MM - BLUE
<3MM - RED

KERTINIZED GINGIVA MM
(MARK ROOT)
FURCATION

POCKETS
>3MM - BLUE
<3MM - RED

KERTINIZED GINGIVA MM
(MARK ROOT)
FURCATION

POCKETS
>3MM - BLUE
<3MM - RED

MOBILITY

SAMPLE



AFFIX LABEL

Tennessee Department of Health
Oral Health Services
Periodontal Charting Record

Med. Alert _____

Circle Box:
Bleeding in Red
Exudate in Blue

C																		MOBILITY																			
B																																					
A																																					
DATES:		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16																				
C																		POCKETS																			
B																		>3MM - BLUE																			
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3 22 16			4	3	5	5	4	5	5	3	4	4	3	3	3	3	3	2	3	3	2	3	3	2	3	3	2	4	3	4	5	4	5	3	5		
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32		31	30	29	28	27	26	25	24	23	22	21	20	19	18	17																					
A																		MOBILITY																			
B																																					
C																																					

Periodontal Charting Record

Instructions and Examples for Periodontal Charting

1. Begin by checking for missing teeth and mobility. Missing teeth are recorded on the form by marking an X over the tooth diagram and an X over the corresponding probing box. (See example).
2. Mobility is recorded in the appropriate box that corresponds with the tooth number.
 - a. Class 1 – Slight mobility, up to 1mm of horizontal displacement in a facial-lingual direction.
 - b. Class 2 – Moderate mobility, greater than 1mm of horizontal displacement in a facial-lingual direction.
 - c. Class 3 – Severe mobility, greater than 1mm of displacement in a facial-lingual direction combined with vertical displacement (tooth depressible in the socket).
3. Periodontal probing readings are recorded on the form. The pocket readings will be recorded in the boxes located above the tooth. Measurements should be recorded as follows:
 - a. Numbers 1 – 3 should be written in blue pencil or ink
 - b. Numbers 4 and above should be written in red pencil or ink
 - c. Bleeding is indicated by circling the box in red – see example
 - d. Suppuration (exudate) is indicated by circling the box in blue – see example
4. Gingival recession can be annotated by drawing a line corresponding to the recession on the lines on the tooth. Each line represents 2mm of recession. Recession can be drawn in blue pencil or ink. (See example)

_____ 0mm – no recession
_____ 2mm
_____ 4 mm

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

Documenting PSR Codes

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

3			2			1			Periodontal Screening and Recording											
3			3			4*			0		5		1		4		0		4	
Sextant Score			Sextant Score			Sextant Score			Month		Day		Year		Year					

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

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

Silver diamine fluoride (SDF) is an applied liquid used to control tooth decay and prevent the disease from progressing. Its application is a conservative approach for the treatment of active tooth decay. At least two applications are necessary to stop the tooth decay.

The procedure:

- Dry teeth
- Place a small amount of SDF on the affected area of the teeth
- Wait approximately one minute to give SDF time to dry
- Rinse
- Do not eat or drink for one hour

Contraindications:

- Allergy to silver
- Painful, sore or raw gums (ulcerative gingivitis or stomatitis)

Possible risks to SDF include, but are not limited to the following:

- The affected area will permanently turn **black**.
- If SDF comes in contact with skin or gums it will leave a temporary discoloration.
- When placing SDF on the restoration the decayed area will become darker.
- There may be a metallic taste in the mouth however, this will quickly go away.
- If the progress of the decay continues, additional treatments may be needed, such as repeating the SDF, a filling, crown, root canal treatment or extraction.

Alternatives to SDF:

- Possible filling, crown, or extraction
- Referral for advance treatment by a specialist

Treatment with silver diamine fluoride does not prevent the need for dental restorations, such as fillings or crowns to repair functions or esthetics. There is a possibility the SDF treatment may not stop the decay and no guarantee of success is granted or implied.

Patient Name: _____

Signature of Patient/Guardian

Date

Signature of witness

Date



El Fluoruro Diamino de Plata (FDP) es un líquido cuya aplicación es usada para controlar las caries y prevenir que la enfermedad se extienda. Su aplicación es un método de conservación el tratamiento de caries activas. Al menos dos aplicaciones son necesarias para detener las caries.

Procedimiento:

- Seque los dientes
- Coloque una cantidad pequeña de FDP en el área afectada de los dientes
- Espere aproximadamente un minuto para dejar que se seque el FDP
- Enjuague
- No coma ni beba por una hora

Contraindicaciones:

- Alergia a la plata
- Encías dolorosas, irritadas, o con inflamación expuesta (gingivitis ulcerativa o estomatitis)

Riesgos posibles del FDP incluyen, pero no se limitan a los siguientes:

- El área afectada se **ennegrecerá** permanentemente.
- Si el FDP entra en contacto con la piel o las encías, causará una descoloración temporal
- Cuando se coloca el FDP en la restauración dental, el área cariada se oscurecerá.
- Puede ser un sabor metálico en la boca, sin embargo, desaparecerá rápidamente.
- Si la caries se extiende, tratamientos adicionales pueden ser necesarios, tales como repetir el FDP, un empaste, corona, tratamiento de conducto radicular o extracción.

Alternativas al FDP:

- Posible empaste, corona, o extracción
- Referencia para tratamiento avanzado por un especialista

Tratamiento con el fluoruro diamino de plata no evita la necesidad de restauraciones dentales, tales como empastes o coronas para reparar funcionalidad o por razones estéticas. Existe la posibilidad de que el tratamiento con FDP no pueda detener la caries, y no se ofrece ni se asume ninguna garantía de éxito.

Nombre del Paciente: _____

Firma del Paciente/Tutor legal

Fecha

Firma del testigo

Fecha

Departamento de Salud de Tennessee
Servicios de Salud Orales



CONSENTIMIENTO INFORMADO PARA
CIRUGÍA BUCAL Y MAXILOFACIAL

Nombre del paciente: _____
Nombre Inicial del segundo nombre Apellido

Procedimiento: Extracción de diente o dientes número: _____

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

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

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

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

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

Firma del paciente, padre, madre o tutor

Fecha

Firma del médico

Fecha

Firma del testigo

Fecha



Tennessee Department of Health
Oral Health Services

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

Patient Name: _____
First Middle Initial Last

Procedure: Extraction (Removal) of Tooth/Teeth _____

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

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

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

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



____ 4. I understand that even if there are no immediate complications from the proposed dental treatment, the area is always subject to breakdown by itself at any time and infection due to the unstable condition of the bone; even the smallest trauma from a toothbrush, chewing hard food, or denture sores may set off a complication.

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

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

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

CONSENT

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

Patient/Parent/Guardian's Signature

Date

Doctor's Signature

Date

Witness' Signature

Date



Departamento de Salud de Tennessee
Servicios de salud bucal

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

Nombre del paciente: _____
Nombre Inicial del segundo nombre Apellido

Procedimiento: Extracción de diente o dientes: _____

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

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

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

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



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

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

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

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

CONSENTIMIENTO

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

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

WHAT TO DO AFTER EXTRACTION OF A TOOTH

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

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

THE CLOT

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

1. **Do not smoke.** You are leaving here with an open wound. If you smoke before it heals, you slow the healing process and cause more pain for yourself.
2. Do not spit, rinse your mouth, or drink through a straw for 24 hours. Eat only soft foods. **Do not** drink carbonated beverages.
3. Do not try to clean the teeth next to the socket for the rest of the day. You should brush and floss your other teeth to reduce bacteria in your mouth.

SWELLING AND PAIN

You may have some swelling and discomfort after oral surgical procedures. A cold compress may help reduce

swelling if begun within 30 minutes and apply gently on and off for 1 to 2 hours, but this is usually not necessary.

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

MEDICATION

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

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

DIET

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

RINSING AND ORAL HYGIENE

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

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



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ED# 1000050695

LOS PASOS A SEGUIR DESPUÉS DE UNA EXTRACCIÓN DE UN DIENTE

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

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

EL COÁGULO

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

1. No fume. Ud. sale de aquí con una herida abierta. Si fuma antes de que cicatrice, hará que se demore el proceso de cicatrización y tenga más dolor.
2. No escupa, ni se enjuague la boca, ni tome líquidos a través de una pajita durante 24 horas, ingiera alimentos blandos solamente. No tome bebidas con gas.
3. Trate de no limpiarse los dientes cerca del hueco en lo que queda del día. Debe cepillarse y usar el hilo dental en el resto de la dentadura para reducir las bacterias en la boca.

INFLAMACIÓN Y DOLOR

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

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

MEDICAMENTOS

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

Si el dolor continua o se intensifica, o si tiene mucha inflamación, o hemorragia o fiebre, llame al departamento de salud inmediatamente.

DIETA

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

ENJUAGUE E HIGIENE BUCAL

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

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



Tennessee Department of Health
Oral Health Services
Dental Encounter

PT. NO:
NAME:
DATE:
ENCOUNTER NO:

ADULT

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

	DESCRIPTION	CODE	PROV	PRG	QTY	REST/REF	REST/REF	REST/REF
D I A G N O S T I C	Periodic Oral Evaluation	D0120		DN				
	Limited Oral Evaluation – Problem Focused	D0140		DN				
	Comprehensive Oral Evaluation	D0150		DN				
	Comprehensive Periodontal Evaluation	D0180		DN				
	Intraoral – Complete Series (Including Bitewings)	D0210		DN				
	Intraoral – Periapical First Radiographic Image	D0220		DN				
	Intraoral – Periapical Additional Radiographic Image	D0230		DN				
	Intraoral – Occlusal Radiographic Image	D0240		DN				
	Bitewing – Single Radiographic Image	D0270		DN				
	Bitewings – 2 Radiographic Images	D0272		DN				
	Bitewings – 4 Radiographic Images	D0274		DN				
	Panoramic Radiographic Image	D0330		DN				
	Caries Risk Assess Doc Finding – Low Risk	D0601		DN				
	Caries Risk Assess Doc Finding – Mod Risk	D0602		DN				
Caries Risk Assess Doc Find – High Risk	D0603		DN					
P R E V	Prophylaxis – Adult	D1110		DN				
	Fluoride Varnish	D1206		DN				
	Silver Diamine Fluoride	D1354		DN				
	Oral Hygiene Instructions	D1330		DN				
R E S T O R A T I V E	Amalgam – 1 Surface	D2140		DN				
	Amalgam – 2 Surfaces	D2150		DN				
	Amalgam – 3 Surfaces	D2160		DN				
	Amalgam – 4 or More Surfaces	D2161		DN				
	Resin-Based Composite – 1 Surface, Anterior	D2330		DN				
	Resin-Based Composite – 2 Surfaces, Anterior	D2331		DN				
	Resin-Based Composite – 3 Surfaces, Anterior	D2332		DN				
	Resin-Based Composite – 4 or More Surfaces, Anterior	D2335		DN				
	Resin-Based Composite, 1 Surface, Posterior	D2391		DN				
	Resin-Based Composite, 2 Surfaces, Posterior	D2392		DN				
	Resin-Based Composite, Three Surfaces, Posterior	D2393		DN				
	Resin-Based Composite, Four or more Surfaces, Posterior	D2394		DN				
	Protective Restoration	D2940		DN				
Core Buildup Including Pins	D2950		DN					
P R O S T H	Crown – Porcelain, Predominately Base Metal	D2751		DN				
	Crown – Porcelain, Noble Metal	D2752		DN				
	Crown – Full Cast Predominately Base Metal	D2791		DN				
	Re-cement Crown	D2920		DN				
	Prefabricated Stainless Steel Crown – Permanent Tooth	D2931		DN				
O S	Extraction – Erupted or Exposed Primary or Permanent	D7140		DN				
	Surgical Extraction – Erupted Tooth or Exposed Root	D7210		DN				
E N D O	Therapeutic Pulpotomy	D3220		DN				
	Pulpal Debridement, Primary and Permanent Teeth	D3221		DN				
	Endodontic Therapy – Anterior	D3310		DN				
	Endodontic Therapy – Bicuspid	D3320		DN				
	Endodontic Therapy – Molar	D3330		DN				
M I S C	Periodontal Scaling & Root Planing – Quadrant	D4341		DN				
	Full Mouth Debridement	D4355		DN				
	Periodontal Maintenance	D4910		DN				
	Alveoloplasty with Extractions – Four or More Teeth	D7310		DN				
	Alveoloplasty without Extractions	D7320		DN				
	Palliative Treatment	D9110		DN				
	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis	D9230		DN				
	Office Visit for Observation – No Other Services Provided	D9430		DN				
	Occlusal Guard	D9940		DN				
	Patient Complete	DCOMP		DN				
	Recheck	3734		DN				
	Smoking Cessation	99401QT		QT				
	TennCare Advocacy	99401T		TO				
TennCare Advocacy	99402T		TO					
Interpreter Codes	INT 1		DN		INT 2	INT 3	INT 4	



Tennessee Department of Health
Oral Health Services
Dental Encounter

PT. NO:
NAME:
DATE:
ENCOUNTER NO:

CHILD

VISIT SETTING 01 02 06

REIM:
PLAN:
NOTE:
DX CODE: Z01.20
DX CODE: Z01.21
DX CODE: K08.9

	DESCRIPTION	CODE	PROV	PRG	QTY	REST/REF	REST/REF	REST/REF
D I A G N O S T I C	Periodic Oral Evaluation	D0120		DN				
	Limited Oral Evaluation – Problem Focused	D0140		DN				
	Oral Evaluation For Child Under 3 Years of Age	D0145		DN				
	Comprehensive Oral Evaluation	D0150		DN				
	Intraoral – Complete Series (Including Bitewings)	D0210		DN				
	Intraoral – Periapical First Radiographic Image	D0220		DN				
	Intraoral – Periapical Additional Radiographic Image	D0230		DN				
	Intraoral – Occlusal Radiographic Image	D0240		DN				
	Bitewing – Single Radiographic Image	D0270		DN				
	Bitewings – 2 Radiographic Images	D0272		DN				
	Bitewings – 4 Radiographic Images	D0274		DN				
	Panoramic Radiographic Image	D0330		DN				
	Caries Risk Assess Doc Finding – Low Risk	D0601		DN				
	Caries Risk Assess Doc Finding – Mod Risk	D0602		DN				
Caries Risk Assess Doc Find – High Risk	D0603		DN					
P R E V E N T I V E	Prophylaxis – Child (0-12 Years)	D1120		DN				
	Prophylaxis – Child (13-20 Years)	D1110		DN				
	Fluoride Varnish	D1206		DN				
	Silver Diamine Fluoride	D1354		DN				
	Oral Hygiene Instructions	D1330		DN				
	Sealant	D1351		DN		02/0	03/0	04/0
	Sealant	D1351		DN		05/0	12/0	13/0
	Sealant	D1351		DN		14/0	15/0	18/0
	Sealant	D1351		DN		19/0	20/0	21/0
	Sealant	D1351		DN		28/0	29/0	30/0
	Sealant	D1351		DN		31/0		
	Preventive Resin Restoration	D1352		DN				
	Space Maintainer – Fixed, Unilateral	D1510		DN				
Re-cement or Re-bond Space Maintainer	D1550		DN					
R E S T O R A T I V E	Amalgam – 1 Surface	D2140		DN				
	Amalgam – 2 Surfaces	D2150		DN				
	Amalgam – 3 Surfaces	D2160		DN				
	Amalgam – 4 or More Surfaces	D2161		DN				
	Resin-Based Composite – 1 Surface, Anterior	D2330		DN				
	Resin-Based Composite – 2 Surfaces, Anterior	D2331		DN				
	Resin-Based Composite – 3 Surfaces, Anterior	D2332		DN				
	Resin-Based Composite – 4 or More Surfaces, Anterior	D2335		DN				
	Resin-Based Composite – One Surface, Posterior	D2391		DN				
	Resin-Based Composite – Two Surfaces, Posterior	D2392		DN				
	Resin-Based Composite – Three, Surfaces Posterior	D2393		DN				
	Resin-Based Composite – 4 or More Surfaces, Posterior	D2394		DN				
	Protective Restoration	D2940		DN				
	Core Buildup Including Pins	D2950		DN				
P R O S	Re-cement Crown	D2920		DN				
	Prefabricated Stainless Steel Crown – Primary Tooth	D2930		DN				
	Prefabricated Stainless Steel Crown – Permanent Tooth	D2931		DN				
O S	Extraction – Erupted or Exposed Primary or Permanent	D7140		DN				
	Surgical Extraction – Erupted Tooth or Exposed Root	D7210		DN				
E N D O	Therapeutic Pulpotomy	D3220		DN				
	Pulpal Debridement, Primary and Permanent Teeth	D3221		DN				
	Endodontic Therapy – Anterior	D3310		DN				
	Endodontic Therapy – Bicuspid	D3320		DN				
	Endodontic Therapy – Molar	D3330		DN				
M I S C	Periodontal Scaling & Root Planing – Quadrant	D4341		DN				
	Full Mouth Debridement	D4355		DN				
	Palliative Treatment	D9110		DN				
	Inhalation of Nitrous Oxide/Analgesia, Anxiolysis	D9230		DN				
	Office Visit for Observation – No Other Services Provided	D9430		DN				
	Patient Complete	DCOMP		DN				
	Recheck	3734		DN				
	TennCare Advocacy	99401T		TO				
	TennCare Advocacy	99402T		TO				
Interpreter Codes	INT 1		DN		INT 2	INT 3	INT 4	

<p style="text-align: center;">Autoclave</p> <p>Make: _____ Model #: _____</p> <p>Packaged instruments processed at _____ ° (F or C – circle one) for _____ minutes.</p>	<p style="text-align: center;">Biological Indicator (BI)</p> <p>Manufacturer: _____</p> <hr/> <p style="text-align: center;">BI Incubator</p> <p>Make: _____ Model: _____</p>
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Date	Autoclave not in use	Load #	Ext & Int Indicator* Color Change Y or N	Time and Temperature Y or N	Time BI placed IN incubator	Time BI taken OUT of incubator	Test BI Results	Control BI Results	Autoclave Cleaned Monthly or every 30 loads	Ultrasonic Monitoring (weekly monitoring)	Initials	Comments
	<input type="checkbox"/>						+	+				
	<input type="checkbox"/>						-	-				
	<input type="checkbox"/>						+	+				
	<input type="checkbox"/>						-	-				
	<input type="checkbox"/>						+	+				
	<input type="checkbox"/>						-	-				
	<input type="checkbox"/>						+	+				
	<input type="checkbox"/>						-	-				
	<input type="checkbox"/>						+	+				
	<input type="checkbox"/>						-	-				
	<input type="checkbox"/>						+	+				
	<input type="checkbox"/>						-	-				

Clinical Competency Checklist for Dental Assistants 1

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

Clinical Competency Checklist for Dental Assistants 1

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

Clinical Competency Checklist for Dental Assistants 2

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

Clinical Competency Checklist for Dental Assistants 2

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

Clinical Competency Checklist for Dental Assistant 3

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

Clinical Competency Checklist for Dental Assistant 3

Delegable Duties	Assistant's Initials	Dentist's Initials	Date of Completed Training
24) Calling in prescriptions to the pharmacist as instructed by the employer/dentist			
25) Performing pulp testing			
26) Packing of pulpotomy paste			
27) Drying canals with absorbent paper points			
28) Taking of alginate impressions for any purpose other than permanent restorations			
29) Placement and removal of socket dressings			
30) Placement and removal of periodontal dressings			
31) Removal of sutures and staples			
32) Taking of oral cytologic smears			
33) Taking of dental plaque smears			
34) Removal of loose or broken bands or brackets			
35) Placement of springs on wires			
36) Placement of hooks on brackets			
37) Placement of chain elastics on brackets			
38) Ligation of arch wires to brackets.			
39) Selection, pre-fitting, cementation curing, and removing of orthodontic bands or brackets			
40) Bending, selecting and pre-sizing arch wires and placing arch wires after final adjustment and approved by the dentist.			
41) Removal of ligature and arch wires			
42) Placement and removal of pre-treatment separators			
43) Fitting, adjusting and cementation of correctional appliances.			
44) Placement of exposure chains and attachments			
45) Exposure of Dental Radiographs			
46) Coronal Polishing			
47) Sealant Application			
48) Nitrous Oxide Monitoring			
49) Expanded Restorative Functions			
50) Expanded Prosthetic Functions			

Note: Any delegable duty not applicable to position mark with N/A, initial and date.



TENNESSEE DEPARTMENT OF HEALTH
TENNESSEE BOARD OF PHARMACY
Controlled Substance Database Administrator
227 FRENCH LANDING, SUITE 300
NASHVILLE, TENNESSEE 37243
(615) 253-1305 OR FAX (615) 253-8782

PRACTITIONER REPORT TO LAW ENFORCEMENT

To: *Insert a local law enforcement agency (Sheriff's Office, Police Department, Judicial District Drug Task Force, or TennCare Investigations):*

From: *Practitioner's name:*

Office address:

Phone number:

Date: _____ *(Must be within 5 business days of incident)*

Re: **Controlled Substance Report / as required by Tenn. Code Ann. §53-11-309(a)**

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

Patient's Name: _____

Patient's Address: _____

Driver's License Number & State: _____

Patient's DOB: _____

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

For Department Use Only

Date Received	<input type="checkbox"/> Approved	Director or Designee Signature	Date of Action
	<input type="checkbox"/> Disapproved		

Servicios de Salud Oral del Departamento de Salud de Tennessee
Consentimiento informado para el uso de óxido nitroso

Nombre del paciente: _____
 Primer nombre Segundo nombre Apellido

El óxido nitroso o "gas hilarante" se usa para pacientes que pueden tener miedo / ansiedad. Este puede emplearse durante el tratamiento dental.

Durante el tratamiento:

- El paciente está despierto.
- El paciente puede hablar.

Los riesgos y complicaciones potenciales temporales pueden incluir, pero no se limitan a:

1. Náusea y vómito.
2. Hormigueo en las manos, pies o cara.
3. Sensaciones de calor en el cuerpo.
4. Sensación de desmayo, de cuerpo pesado o flotante.
5. Excesiva risa o conversación.

Pude discutir el uso de la inhalación de óxido nitroso con el Dr./la Dra. _____

y hacer preguntas. Doy mi consentimiento para el uso de inhalación de óxido nitroso en la manera descrita.

Firma del paciente, padre o tutor

Fecha

Firma del doctor

Fecha

Firma del testigo

Fecha

MEDICAL CONSULT FOR PREGNANT DENTAL PATIENTS

Patient Name: _____ DOB: _____ Date: _____

Expected Due Date: _____

Pregnancy/Medical History: _____

This patient has presented to our clinic for dental treatment. The following is standard protocol for our treatment of pregnant dental patients:

- Necessary radiographs will be taken with lead shielding of the abdomen and the thyroid area
- Treatment may include any of the following:
 - Teeth cleaning
 - Topical Fluoride Varnish 5% NaF
 - Fillings
 - Extractions
- If local anesthetic is used, 2% Lidocaine with epinephrine 1:100,000 is used most often
- For non-narcotic pain management, OTC Acetaminophen will be recommended
- If antibiotic is needed, either Amoxicillin or Clindamycin will be prescribed
- *According to the National Maternal and Child Oral Health Consensus Statement “oral health care, including the use of x-rays, pain medication and local anesthesia is safe throughout pregnancy”, 2012; <http://www.mchoralhealth.org>*

Thank you,
Dentist: _____

Please sign below for medical clearance or indicate further guidance for dental treatment:

• I agree with above protocol : signed: Dr. _____ date: _____

• I disagree with the above mentioned protocol and would like to provide additional guidance:

Signed: Dr. _____ date: _____

Please return to: _____ County Health Department Dental Clinic

Address: _____

Phone: _____

Fax: _____

**TENNESSEE DEPARTMENT OF ENVIRONMENT AND CONSERVATION
DIVISION OF RADIOLOGICAL HEALTH**

NOTICE TO PREGNANT WORKERS

In “State Regulations for Protection Against Radiation” 0400-20-05-.56 the Tennessee Department of Environment and Conservation has established a dose limit of 0.5 rem to an embryo/fetus from occupational exposure during a woman’s entire pregnancy. A woman may declare her pregnancy by notifying the licensee and/or registrant in writing of the pregnancy along with an estimated date of conception so that the estimated dose to the embryo/fetus prior to the declaration of pregnancy can be determined. A woman cannot be required by her employer to make this declaration of pregnancy, and a woman may withdraw her declaration of pregnancy at any time. The decision to make a declaration of pregnancy and/or to withdraw the declaration of pregnancy is strictly a woman’s choice and is entirely voluntary.

The dose to an embryo/fetus is determined by taking the sum of the deep-dose equivalent to the declared pregnant woman, and the dose to the embryo/fetus from radionuclides in the embryo/fetus and radionuclides in the declared pregnant woman. The licensee and/or registrant using ALARA shall make efforts to avoid substantial variation above a uniform monthly exposure rate to a declared pregnant woman.

If the dose to the embryo/fetus is found to be 0.45 rem or greater when a woman declares her pregnancy, then for the remainder of the pregnancy the embryo/fetus is permitted an additional dose not exceeding 0.05 rem.

Any woman that does not declare her pregnancy or withdraws her declaration of pregnancy shall be subject to the normal occupational dose limits outlined in “State Regulations for Protection Against Radiation” 0400-20-05-.50.

Your employer is required to provide guidance and instruction concerning prenatal radiation exposure to allow women who may become pregnant during their employment to make an informed decision on whether or not to formally declare their pregnancy. Additional information concerning prenatal radiation exposure may be obtained by contacting the Department of Environment and Conservation, Division of Radiological Health at (615) 532-0364.

**DEPARTAMENTO DE MEDIO AMBIENTE Y CONSERVACIÓN DE TENNESSEE
DIVISIÓN DE SALUD RADIOLÓGICA**

AVISO A LAS TRABAJADORAS EMBARAZADAS

En el “Reglamento Estatal de Protección Contra la Radiación”, 0400-20-05-.56, el Departamento de Medio Ambiente y Conservación de Tennessee ha establecido un límite de dosis por exposición ocupacional de 0.5 rem para el embrión o feto durante todo el embarazo de una mujer. Una mujer puede declarar su embarazo mediante notificación escrita al titular de la licencia y/o del registro que incluya una fecha estimada de concepción, de modo que pueda determinarse la dosis estimada al embrión o feto antes de la declaración de embarazo. El empresario no puede obligar a una mujer a realizar esta declaración de embarazo, y esta puede retirar su declaración de embarazo en cualquier momento. La decisión de hacer una declaración de embarazo y/o de retirar la declaración de embarazo le pertenece estrictamente a ella y es totalmente voluntaria.

La dosis al embrión o feto se determina sumando la dosis profunda equivalente a la mujer embarazada declarada y la dosis al embrión o feto procedente de los radionucleidos presentes en el embrión o feto y de los radionucleidos presentes en la mujer embarazada declarada. El titular de la licencia y/o del registro que utilice ALARA hará lo posible por evitar una variación sustancial por encima de una tasa de exposición mensual uniforme a una mujer embarazada declarada.

Si se determina que la dosis para el embrión o feto es de 0.45 rem o más cuando una mujer declara su embarazo, durante el resto del embarazo se permitirá una dosis adicional al embrión o feto que no supere 0.05 rem.

Toda mujer que no declare su embarazo o retire su declaración de embarazo estará sujeta a los límites de dosis ocupacional normales descritos en el “Reglamento Estatal de Protección Contra la Radiación” 0400-20-05-.50.

Su empresa está obligada a proporcionar orientación e instrucciones relacionadas con la exposición prenatal a la radiación para permitir que las mujeres que queden embarazadas durante su empleo tomen una decisión informada sobre la conveniencia o no de declarar formalmente su embarazo. Para más información sobre la exposición prenatal a la radiación, póngase en contacto con la División de Salud Radiológica del Departamento de Medio Ambiente y Conservación al (615) 532-0364.

CAUTION

**IF YOU ARE PREGNANT, OR
THINK YOU MIGHT BE
PREGNANT, TELL THE
TECHNOLOGIST BEFORE
HAVING AN X-RAY COMPLETED**



CUIDADO

**SI ESTA USTED EMBARAZADA
O CREE ESTARLO, INFORME
AL TECNICO DE RAYOS X
ANTES DE REALIZAR LA
PRUEBA DE RAYOS X**

SECTION 3

Quality Improvement & Quality Assurance Review Instrument

**TENNESSEE DEPARTMENT OF HEALTH
COMMUNITY HEALTH SERVICES
ORAL HEALTH SERVICES SECTION**

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



Following is the hyperlink referring to Quality Improvement Information:

- I. Quality Improvement Manual, 30th Edition (as of July 2022):
[Quality Improvement Manual](#)

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

PATIENT'S CHART NUMBER

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

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

**QUALITY ASSURANCE INSTRUMENT
DENTAL RECORD REVIEW**

Dentist _____

Clinic Site _____ Reviewer _____
CSMD (2x yearly) 1ST date: _____ (within normal limits/outside normal limits)
2nd date: _____ (within normal limits/outside normal limits)
CPR Expiration Date _____ License Expiration _____
Malpractice Expiration Date _____ DEA Expiration _____
CE Review _____ Clinical Privileges (hire date/prn) _____
Declaration of Health _____

COMMENTS:

RECOMMENDATIONS:

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

SIGNATURE OF DENTIST **DATE OF SIGNATURE**

SIGNATURE OF REVIEWER **DATE OF SIGNATURE**

GUIDELINES AND CRITERIA FOR STANDARDS OF ACCEPTABLE QUALITY PUBLIC HEALTH DENTISTRY

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

A. MEDICAL/DENTAL HISTORY AND CONSENT (PH-3990)

1. Key patient information (address, phone number, emergency information, and source of payment is on the appropriate form or the electronic record. The health questionnaire (PH-3990)) contains **no** unanswered questions. Questions that are answered yes, must be explained, i.e. Are you seeing a Physician – Yes – Why.
2. Medical conditions or medications requiring an alert are flagged. Alerts are to be flagged using appropriate stickers for Med Alerts and Allergies or by using a Red Pen. Stickers or red annotations are to be placed on the Health History for Dental Services (PH-3990), and on the Clinic Oral Health & Treatment Record (PH-0205A) or in the appropriate location in the electronic record.
3. The medical history (PH-3990) and consent for treatment are signed and dated by the patient or parent/guardian and the dentist. The patient's name must be written in the treatment consent line by the patient/parent/guardian.
4. The medical history (PH-3990). is updated at each appointment, and any change is noted on the appropriate form, in the electronic record or in the progress note. A new Health History must be completed annually.

B. PATIENT EXAMINATION (PH-0205B)

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

C. RADIOGRAPHS

1. Radiographs have proper density, contrast, and detail.
2. Periapical radiographs include all of the crown, roots, and surrounding bone in the area of observation and are not distorted or overlapped (where anatomically possible). Bitewing radiographs split the contacts if possible and include the distal of the cuspids and the mesial of the last tooth in the arch. Bitewings are taken all initial exam appointments when there are close posterior contacts and updated based upon carious activity, caries risk, disease activity or specific problems. Recall radiographs are taken at appropriate intervals.
3. A radiograph of diagnostic quality is taken prior to extracting any tooth (except primary teeth near exfoliation). Anterior periapicals or panorex radiograph must be taken prior to any restorative procedures performed on anterior teeth.

D. TREATMENT

1. The treatment for each patient is based on the history, examination, and diagnosis. Appropriate treatment includes but is not limited to introduction of staff to patient, review of health history, patient education, discussion of findings and treatment plan, offers opportunity for patient feedback or questions, and provides description of treatment to be rendered. The treatment follows a logical sequence. Normally, with minor variations, this is:
 - a. Relief of pain and discomfort
 - b. Elimination of infection and traumatic conditions
 - c. Treatment Plan must be developed for patients undergoing comprehensive care
 - d. Caries control (removal of soft, deep caries)
 - e. Prophylaxis, preventive procedures, and oral hygiene instruction
 - f. Endodontic therapy
 - g. Periodontal therapy
 - h. Necessary extractions
 - i. Restoration of teeth
 - j. Replacement of teeth
 - k. Placement of the patient on an individualized recall schedule
2. *Informed Consent for Oral & Maxillofacial Surgery* (PH-3432) or *Informed Consent for Patients Taking Oral Bisphosphonates* (PH-4035) is completed for all oral surgery procedures. If the patient has taken an Oral Bisphosphonate drug, both forms must be filled out. If the patient has no previous history of taking Oral Bisphosphonates just the *Informed Consent for Oral & Maxillofacial Surgery* (PH-3432) needs to be completed.

E. PROGRESS NOTES

1. All progress notes are legible, dated, and signed by the provider on the date of service in blue or black ink, using signature found on Legal Signature Page, of dentist, hygienist or assistant and credentials (DDS) and should be completed at time of service.
2. Documentation of services (treatment) rendered contains the following at a minimum: (see example below)
 - a. Date of service
 - b. Tooth number, if appropriate, in tooth number block
 - c. Description of the service
 - d. Anesthetic used, if any – including quantity
 - e. Materials used, if any – i.e. shade of comp, brand of amalgam, type of base etc.
 - f. Prescriptions or medications dispensed including name of drug, quantity, and dosage- Documentation of CSMD check placed in the progress note prior to any narcotics being prescribed.
 - g. Additional comments on referrals, consultations, and instructions
3. Standardized charting of treatment is completed in the appropriate tooth grids.
4. Documentation of referral is kept in the patient's chart.
5. A recall plan or next visit is included in the progress notes.
6. Errors should never be corrected with white out. A line should be drawn through the mistake to avoid the impression that a record may have been altered. CID (Correction in Documentation) is written immediately above the mistake, along with initials and date (if different from date of original entry).

Example of Progress Note:

1/18/07

Pt. presents for operative #S (DO) & # T (M)

Health History reviewed. NKDA. Pt. taking no meds. OHI reviewed.

Caries # S (DO), #T (M).

Tx plan:

1. Today: amalgam #S (DO), #T (M), Used ½ carp 2% Lido with epi 1:100,000. Removed all caries. #T – acid etched, 34% Caulk, bonded with Prime and bond NT, placed flowable composite, (Vivadent) shade A2. # S – placed amalgam (Tytin) checked margins and occlusion.

2. Findings & treatment explained to pt. Pt. dismissed in stable status.

3. Appt. made for #L (pulp & SSC).

John Doe, DDS

F. OUTCOME MEASURES

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

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

PATIENT'S CHART NUMBER

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

Y – Yes N – No E – Not Applicable I – Insufficient information to determine

PATIENT'S CHART NUMBER

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

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

**QUALITY ASSURANCE INSTRUMENT
DIRECT OBSERVATION OF PATIENT CARE**

Dentist _____

Clinic Site _____

Reviewer _____

CSMD Check _____ **(within normal limits; outside of normal limits)**

COMMENTS:

RECOMMENDATIONS:

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

SIGNATURE OF DENTIST

DATE OF SIGNATURE

SIGNATURE OF REVIEWER

DATE OF SIGNATURE

GUIDELINES AND CRITERIA FOR STANDARDS OF ACCEPTABLE QUALITY PUBLIC HEALTH DENTISTRY

I. QUALITY OF PATIENT CARE SERVICES

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

A. DIAGNOSIS

1. An initial or recall examination is conducted on all patients receiving comprehensive and preventive care; A limited examination is conducted on problem focused areas.

a. A caries risk assessment should be completed at the time of the initial or recall examination

2. Radiographs

a. Initial radiographs for an adult patient consist of individualized films including bitewings with panoramic exam or bitewings and selected periapicals. A full-mouth intraoral radiographic examination is appropriate when the patient presents with clinical evidence of generalized dental disease or extensive dental treatment.

b. For children with primary teeth only, radiographs are taken if proximal surfaces of the primary teeth cannot be visualized or if there are specific problems.

c. For children with a transitional dentition, or an adolescent with permanent dentition, initial radiographs should consist of appropriate posterior bitewings with panoramic exam or posterior bitewings and selected periapical images.

d. Recall radiographs (bitewings) are taken at a frequency based on caries activity, caries risk, disease activity, or specific problems but should be taken at least once annually or more frequently if needed.

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

3. Radiograph Techniques

a. Appropriate shielding to include thyroid collar is used on all patients receiving radiographs.

b. Film positioners are used. Neither patient nor staff holds the film during exposure.

c. Staff is protected from scattered radiation during film exposure.

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

B. INFECTION CONTROL

1. Hands are washed thoroughly before placement of PPE, immediately prior to putting on gloves, after removal of gloves, and after removal of PPE with antimicrobial soap or hand sanitizer (60-95% Alcohol)
2. Required Protective attire
 - Gowns- long-sleeved, below the knee cuffed gowns. All procedures require a back facing gown. Gowns must be changed between patients.
 - N95 or level 3 masks
 - Face Shield- closed at the top, to or below the chin, and to the ears
 - Gloves- nitrile and surgical gloves for oral surgery and must be placed over the gown cuffs
 - Headcovers are recommended
 - Shoe protectors or designated shoes are recommended
3. PPE must be removed before leaving patient care or sterilization area
4. Dental unit waterlines to all instruments (high-speed handpiece, air/water syringe, and ultrasonic scaler) are flushed for 2 minutes at the beginning of each clinic day and for a minimum of 20-30 seconds after use on each patient. Dental unit waterlines must be treated with appropriate products, and all water monitoring recommendations must be adhered to.
5. After thorough cleaning, all heat-stable instruments, including handpieces, are autoclaved. Handpieces, to include low speed attachments & motors must be sterilized between patients.
6. Disposable covers and disposable supplies are used whenever possible. Disposable items are never reused.

C. PREVENTION

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

D. OPERATIVE DENTISTRY

1. Work practice controls are utilized to reduce formation of aerosols, droplets, and spatter. A water-cooling spray must be used with high-speed tooth reduction.
2. All restorations reproduce sound tooth contours, restore or achieve interproximal contact, and have flush margins. Bases are used appropriately.
3. Significant interproximal carious lesions on primary teeth are restored with stainless steel crowns.

The agitator of the amalgamator functions under a protective cover. Amalgam scrap is stored in a tightly closed container and recycled properly, to include extracted teeth with amalgam in them.

E. PROSTHODONTICS

1. Partial Dentures

Clinically Acceptable

2. Complete Dentures

Clinically Acceptable

3. Fixed

Clinically Acceptable

F. ENDODONTICS

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

G. PERIODONTICS

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

H. ORAL SURGERY

1. When teeth are extracted, all portions of the tooth are removed, except under circumstances where injury to the surrounding hard and/or soft tissues is likely to occur with further attempts at retrieval. If it is necessary to leave a root tip, the patient is informed; treatment options including referral are discussed; and all pertinent information is documented in the patient's record.
2. A radiograph of diagnostic quality is taken prior to extracting any tooth (except primary teeth near exfoliation).

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

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

I. EMERGENCY TREATMENT

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

CLINICAL PRIVILEGES REQUEST FORM for DENTISTS

Except where specified elsewhere, all staff dentists are permitted to treat minor conditions in the specialty areas, provided such a condition does not constitute a threat to the life, wellbeing, or essential function of the patient.

Check items (category and ages) for which privileges are requested.

I hereby request the following STAFF Status

Adult and Pediatric

The Scope (Type) of Practice at the Health Department is General Dentistry Services and consultation.

Age Specific

- Age less than 30 days or less than 3 kg. – **Consultation Only**
- Age 30 days to 3 years old
- Age 3 years to 21 years old
- Age 21 years and over

Procedure Specific:

- Preventive Dentistry
- Operative dentistry
- Endodontics
- Periodontics
- Removable Prosthodontics
- Fixed Prosthodontics
- Oral Surgery

I hereby request clinical privileges in the department/service checked above.

Name (Printed Legibly or Typed)

Signature

Date

List Primary Work Site _____ Secondary Clinical Sites _____

A. Preventive Dentistry

Privileges Requested To Perform		Training	Experience	Credentials Committee's Recommendation	
Yes	No			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B. Operative Dentistry

Privileges Requested To Perform		Training	Experience	Credentials Committee's Recommendation	
Yes	No			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. Endodontics

Privileges Requested To Perform		Training	Experience	Credentials Committee's Recommendation	
Yes	No			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. Periodontics

Privileges Requested To Perform		Training	Experience	Credentials Committee's Recommendation	
Yes	No			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(Circle one) I have/have not treated/performed an adequate number to maintain proficiency for gingivectomy (D4210, D4211)

Approximate # of cases treated/performed during last two years _____

Relevant CME course (Include title and number of CEUs earned) or explain experience.

E. Removable Prosthodontics

Privileges Requested To Perform		Training	Experience	Credentials Committee's Recommendation	
Yes	No			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

F. Fixed Prosthodontics

Privileges Requested To Perform		Training	Experience	Credentials Committee's Recommendation	
Yes	No			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

G. Oral Surgery

Privileges Requested To Perform		Training	Experience	Credentials Committee's Recommendation	
Yes	No			Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Circle one) I have/have not treated/performed an adequate number to maintain proficiency for excision of benign lesion (D7410), removal of exostosis per site (D7471) and frenulectomy (D7960).

Approximate # of cases treated/performed during last two years _____

Relevant CME course (Include title and number of CEUs earned) or explain experience.

I hereby request clinical privileges in the department/service checked above.

Name (Printed Legibly or Typed)

Signature

Date

DECLARATION OF HEALTH

Do you attest that you are in full possession of physical and mental abilities to successfully perform the duties of your position?

_____Yes _____No

Most Recent Examination Date: _____

CONTINUING EDUCATION CREDITS (CMEs)

Do you attest that you have attended CME activities in the past two years that relate to your area of practice, and that you will be able to provide proof of attendance and program content upon request?

Yes _____ No _____

I certify the information in this document is true and complete.

_____ Date _____
Signature

Print Name

The Tennessee Department of Health does not discriminate on the basis of race, color, sex, religion, or age.

SECTION 4

Protocol for Management of Medical Emergencies

**TENNESSEE DEPARTMENT OF HEALTH
COMMUNITY HEALTH SERVICES
ORAL HEALTH SERVICES SECTION**

SECTION 5

Infection Control Policies and Procedures & Additional Recommendations and Guidelines

**TENNESSEE DEPARTMENT OF HEALTH
COMMUNITY HEALTH SERVICES
ORAL HEALTH SERVICES SECTION**

INFECTION CONTROL POLICIES AND PROCEDURES

For Infection Control Policies and Procedures for the Tennessee Department of Health, access the manual: [TDH - Infection Control Manual - 2017](#)

I. SCREENING AND REFERRAL PROGRAMS

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

A. Precautions:

1. Use of disposable instruments is recommended and sharps should be disposed of in sharps containers. Other disposable items should be disposed of appropriately.
2. It is recommended that charting of records be done by another person. If this is not possible, you must ensure that all Infection Control Protocols are followed to prevent any cross-contamination.

B. Proper Handling of Waste

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

II. DENTAL SEALANT PROGRAMS IN A PORTABLE DENTAL CARE ENVIRONMENT

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

III. PUBLIC HEALTH DENTAL CLINICS

Dental personnel in public health in Tennessee ***must*** comply with [OSHA's Bloodborne Pathogens Standard](#).

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

ADDITIONAL RECOMMENDATIONS AND GUIDELINES

I. PREVENTION OF INFECTIVE ENDOCARDITIS (IE)

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

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

[Prevention of Viridans Group Streptococcal Infective Endocarditis: A Scientific Statement From the American Heart Association](#)

II. ANTIBIOTIC PROPHYLAXIS FOR DENTAL PATIENTS WITH TOTAL JOINT REPLACEMENT

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

For an Information Statement from the AAOS regarding [Antibiotic Prophylaxis for Patients after Total Joint Replacement](#).

AAOS and the ADA Release clinical practice guidelines on “The Prevention of Orthopaedic Implant Infections in Patients Undergoing Dental Procedures”, December 7, 2012, [AAOS - ADA Clinical Guidelines](#)

[Management of Patients with Prosthetic Joints](#)

[The use of prophylactic antibiotics prior to dental procedures in patients with prosthetic joints: Evidence-based clinical practice guideline for dental practitioners—a report of the American Dental Association Council on Scientific Affairs - ScienceDirect](#)

III. TUBERCULOSIS INFECTION CONTROL RECOMMENDATION - CONSIDERATIONS FOR DENTISTRY

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

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

IV. NITROUS OXIDE OCCUPATIONAL SAFETY

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

[AAPD Nitrous Oxide Safety](#)

POTENTIAL BENEFITS

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

SECTION 6

Statutes & Rules of the Tennessee Board of Dentistry

**TENNESSEE DEPARTMENT OF HEALTH
COMMUNITY HEALTH SERVICES
ORAL HEALTH SERVICES SECTION**

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

- I. **GENERAL RULES:** [Rules of the Tennessee Board of Dentistry](#)
- II. **PRACTICE OF DENTISTRY:** [Rules Governing the Practice of Dentistry](#)
- III. **PRACTICE OF DENTAL HYGIENE:** [Rules Governing the Practice of Dental Hygienists](#)
- IV. **PRACTICE OF DENTAL ASSISTING:** [Rules Governing the Practice of Dental Assistants](#)
- V. **TENNESSEE CODE ANNOTATED** – Title 63; Chapter 5 Dentists: [TCA § 63-5](#)

SECTION 7

Annual Clinical Safety Checklist

**TENNESSEE DEPARTMENT OF HEALTH
COMMUNITY HEALTH SERVICES ORAL
HEALTH SERVICES SECTION**

Annual Clinical Safety Checklist

Legal Signature Page (page 7.02)

A copy of the Legal Signature Page with all current clinical staff members' printed name with credentials, legal signature with credentials, and the date of signature, should be kept in the front of the PPG Manual and updated annually.

Site Specific Exposure Control Plan (page 7.03)

Site specific Exposure Control Plans must be updated annually.

Evaluation of Safer Sharps Devices (page 7.04)

Evaluation of safer sharps devices with the solicitation of staff will be provided annually.

Safer Sharps Devices and Exclusion List of Non-Safe Sharps (page 7.04)

A copy of the safer sharps devices used within the program and a list of non-safe sharps used within the program, updated annually.

Personal Protection Equipment (PPE) Certification (page 7.05)

A regional specific PPE list must be signed and dated by the regional dental director annually.

Written Housekeeping Plan (page 7.06)

A regional specific Written Housekeeping Plan must be signed and dated by the regional dental director annually.

Environmental Air Purifier System Maintenance Log (page 7.07)

Maintenance is required based on manufacturer's guidance or PPG guidance and depends on how they were installed. Reference section 9.22 PPG Manual for Guidance.

Sharps Injury Log (page 7.08)

A sharps injury log for all percutaneous injuries occurring from contaminated sharps must be maintained annually; records should be retained for five (5) years.

Site Specific Exposure Control Plan

County Health Department Dental Clinic

(County Name)

(Date)

OSHA Regulation: [1910.1030\(c\)\(1\)\(iv\)](#) Exposure Control Plan shall be reviewed and updated at least annually and whenever necessary to reflect new or modified tasks and procedures which affect occupational exposure and to reflect new or revised employee positions with occupational exposure.

The TDH Exposure Control Plan is a broad all-inclusive plan; the following pages contain site specific exposure control plan information.

Exposure Determination – identification of those individuals whose classification includes tasks which may include skin, eye, mucous membrane or parenteral contact with blood or other potentially infectious materials.

Name

Title

Evaluation of Safer Medical Devices (Dentistry)

_____ Clinical _____
(regional program name) (date)

OSHA Regulation: [1910.1030\(c\)\(1\)\(iv\)\(B\)](#) Document annually consideration and implementation of appropriate commercially available and effective safer medical devices designed to eliminate or minimize occupational exposure.

The employer must simply keep abreast of new and emerging technologies and solicit input from non-managerial employees to determine if the facility's chosen device remains preferable to any newly developed products. This should be documented in the Exposure Control Plan.

June 2023

After reviewing several reputable sources and with input from non-managerial staff, Kayla Dodson, RDH and Dr. Hayes found no new options to consider for the Clinical Dental Program. S. Hayes, DDS

Safer Sharps Devices used within the

_____ Clinical _____
(regional program name) (date)

List the device and how it is being used

Retractable scalpels.

Exclusion List of Non-Safe Sharps used within the

_____ Clinical _____
(regional program name) (date)

List the brand name, what the device is and why it is being used

Monoject/Septoject/Darby Dental needles. No safer and more efficient device available. Darvy/Miltex/Hu-Friedy/johnson Suture needles. No safer and more efficient device available.

Personal Protection Equipment (PPE) Certification

County Health Department Dental Clinic

(County Name)

(Date)

OSHA Regulation [1910.1030\(d\)\(3\)\(i\)](#) *Provision*. When there is occupational exposure, the employer shall provide, at no cost to the employee, appropriate personal protective equipment such as, but not limited to, gloves, gowns, laboratory coats, face shields or masks and eye protection, and mouthpieces, resuscitation bags, pocket masks, or other ventilation devices. Personal protective equipment will be considered appropriate only if it does not permit blood or other potentially infectious materials to pass through to or reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

PPE	Use	Maintenance	Disposal

Due to the safety and importance of PPE, all PPE, such as mask, gloves, jackets, etc., purchased for use in TDH dental clinics must be associated with colors of the medical/dental profession, examples are blue, green, pink, purple, teal, white, and yellow.

(Regional Dental Director)

(Date)

Written Housekeeping Plan
County Health Department Dental Clinic

(County Name)

(Date)

OSHA Regulation [1910.1030\(d\)\(4\)\(ii\)\(A\)](#) Contaminated work surfaces shall be decontaminated with an appropriate disinfectant after completion of procedures; immediately or as soon as feasible when surfaces are overtly contaminated or after any spill of blood or other potentially infectious materials; and at the end of the work shift if the surface may have become contaminated since the last cleaning.

To provide a biosafe environment for healthcare workers and their patients, a cleaning schedule shall be established.

Items to be cleaned	Barriers to be used	Solutions Necessary	Procedural Activities	Time Line

(Regional Dental Director)

(Date)

Environmental Air Purifier System Maintenance Log

VidaShield or Jade Air Purifiers

Maintenance is required based on manufacturer’s guidance or PPG guidance and depends on how they were installed.

Reference section 9.19 PPG Manual for Guidance.

Lamp and Filter Maintenance:

Original installation Date _____
 Lamp change frequency _____
 Filter Change frequency _____

Maintenance	Lamp	Filter	Filter	Filter	Filter
		Q1	Q2	Q3	Q4
2020					
2021					
2022					
2023					
2024					
2025					
2026					
2027					
2028					
2029					
2030					

Establishment/Facility Name: _____

Sharps Injury Log

Year: _____

Date	Case / Report No.	Type of Device (e.g. syringe, suture needle)	Brand Name of Device	Work Area Where Injury Occurred (e.g. Geriatrics, Lab)	Brief Description of How The Incident Occurred [i.e. procedure being done, action being performed (disposal, injection, etc.), body part injured]

29 CFR 1910.1030. OSHA's Bloodborne Pathogens Standard, in paragraph (h)(5), requires an employer to establish and maintain a Sharps Injury Log for recording all percutaneous injuries in a facility occurring from contaminated sharps. The purpose of the Log is to aid in the evaluation of devices being used in healthcare and other facilities and to identify problem devices or procedures requiring additional attention or review. This log must be kept in addition to the injury and illness log required by 29 CFR 1904. The Sharps Injury Log should include all sharps injuries occurring in a calendar year. The log must be retained for five (5) years following the end of the year to which it relates. The log must be kept in a manner that preserves the confidentiality of the affected employee.

SECTION 8

Annual Clinical Hazardous Materials and Supplies Inventory

**TENNESSEE DEPARTMENT OF HEALTH
COMMUNITY HEALTH SERVICES
ORAL HEALTH SERVICES SECTION**

Annual Clinical Hazardous Materials & Supplies Inventory

List of Hazardous Chemicals (page 8.01)

List of hazardous chemicals must be reviewed annually and updated if needed

Inventory of Chemicals, Materials, and Supplies (page 8.02)

Inventory of chemicals, materials and supplies must be reviewed annually and updated if needed

Infection Control and Hazard Communication Training (page 8.03)

Infection Control and Hazard Communication Training is provided annually with appropriate documentation. **Attach Signed/Dated Documentation.**

Safety Data Sheets (SDS)

SDS must be reviewed annually and updated as needed.

Attach Documentation in order listed on the log.

Insert Infection Control & Hazard Communication
Training Log (must be signed and dated)

Safety Data Sheets (SDS) Information

Please place sheets in same order as reflected on the
log

SECTION 9

Dental Clinic Operations Handbook

**TENNESSEE DEPARTMENT OF HEALTH
COMMUNITY HEALTH SERVICES
ORAL HEALTH SERVICES SECTION**



Dental Clinic Operations Handbook

9.02- Equipment Maintenance Schedules

9.03- Preventative Maintenance Checklist (for reference)

9.05- Clinical Mandates and Recommendations

9.07- Pediatric Screening Blood Press Values

Requiring Further Evaluation

9.08- Medications in Drug Room

9.09- Spore Testing

9.10- Water Protocol

9.12- Autoclave Usage and Maintenance

9.13- Digital Radiography

9.14- Refrigerators in Clinic

9.14- HIPAA Compliance: Sending a Secure Email

9.15- Nitrous Oxide Work Practices

9.16- Silver Diamine Fluoride

9.18- ASTDD SDF Fact Sheet

9.19- Environmental Air Purifier Systems

Equipment Maintenance Schedules

Annually

1. Annual inspection/certification of autoclaves
2. Change Dentapure 365 water line treatment cartridges on each chair.
3. Service air compressor. Change oil (if your clinic has one that uses oil) and filters (Repair tech needed. Not done by dental staff)
4. Replace Amalgam separator collection canister – (May be done sooner if sediment is to the fill line)

Biannually

1. Waterline testing
2. Air filters in Vidashield air remediation units
 - Units wired to run during clinic hours: filters should be changed every 6 months

Quarterly

1. Air filters in Vidashield air remediation units
 - Units wired to run constantly: filters should be changed every 3 months

Monthly

2. Clean Autoclave monthly or every 30 loads
3. Change suction traps on chairs and main trap at vacuum

Weekly

1. Run Attest spore test for each sterilizer in use
2. Assess light output intensity of curing lights with appropriate radiometer
3. High volume evacuator (HVE) should be cleaned with approved cleaner
4. Saliva Ejector traps changed, run suction cleaner through
5. Check the oil level in compressor (dental staff)

Daily use items

1. Inspect all hand instruments and handpieces.
2. Handpieces
 - a. Follow manufacturer's instructions.
 - b. Autoclave all handpiece parts prior to each use.
 - c. Lubricate and run prior to sterilization if indicated.
 - d. Never run handpieces without a bur in place.
 - e. Run water through lines 2 minutes at the beginning of the day and 20-30 seconds between patients.
3. Ultrasonic cleaner should be emptied and cleaned on a daily basis. Enzymatic cleaner should be placed in the ultrasonic for proper cleaning of instruments. Instruments should be placed in ultrasonic using utility gloves. Hand scrubbing of instruments is not recommended.

Preventative Maintenance Checklist

Frequency	Equipment/Item	Procedure
As Needed	Ultrasonic Cleaner	Empty and Drain
Daily Morning	Master Switches	Turn on
Daily Morning	Sterilizer	Check water level, (distilled water only). Wipe chamber & damp cloth
After Each Use	Operatory	Wipe off upholstery with mild detergent & wipe off cooled light shield with damp cloth. All clinical surfaces should be cleaned and disinfected with approved agents (Example: Discide wipes- one minute contact).
After Each Use	Portable Hand Sanitizer	Disinfect after each use; or use hands-free sanitizer dispenser
After Each Use	Dental Burs/Endo Files	Dental burs/Endo Files are considered single use/disposable devices. Any orders placed on or after July 1, 2023 should be for sterile individually packaged single use/disposable burs/endo files. The exception is finishing burs may be reprocessed (autoclaved) per manufacturer's guidance. Current inventory should be sterilized prior to use and disposed of. Current inventory will be replaced with new sterile individually packaged single use burs/endo files as orders are received.
After Each Use	Digital Sensors	Inspect wipe sensors and cords with agent to clean and disinfect per manufacturer's guidelines- Barriers should be used every time
Daily Evening	Compressor	Drain water from tank (for compressors without dryers)
Daily Evening	Master Switches	Turn off
Daily Evening	Operatory/Clinic Area	Turn off delivery unit & Replace chairside vacuum solids collector and all sinks and countertops should be cleaned and disinfected with approved agents (Example: Discide wipes- one minute contact).
Daily Evening	DentaPure	Empty water bottle and replace empty bottle back over
Weekly	Amalgam Separator	Check solids level to ensure below full line.
Weekly	Dental Clinic Floors	Floors should be cleaned weekly and as needed if visibly soiled.
Weekly	Compressor	Check oil level (on lubricated heads) and fill as necessary
Weekly	Vacuum	Check for water leaks. Check and clean solids collectors

Preventative Maintenance Checklist (continued)

Frequency	Item	Procedure
Weekly	Operatory	Run non-foaming cleaner through suction lines (end of day on last day of week) & pour small amount into cuspidor bowl. Flush water lines on delivery systems (with handpieces removed)
Weekly	Sterilizer	Drain water from tank (except Statims); clean and inspect gaskets, chamber, and filters per manufacturer's instructions.
Monthly	Compressor	Inspect moisture indicator on compressors with dryers (pink means desiccant drying chamber needs service or replaced). With Compressor running; check for air leaks on compressor, tubing and connections. Check that air intakes and cooling fans are free of blockage.
Monthly	Operatory	Clean inside surfaces on light shields and reflectors with damp
Monthly	Sterilizer	Run with cleaner as specified by Manufacturer.
Annually*	Compressor	Oil change (on compressors with lubricated heads), Change Air Intake Filters, Change Dryer Assembly Filters (if applicable and needed), Clean coalescing filter bowl, check float & drain. Verify compressor cycles between 80 to 100psi.
Annually*	Vacuum	Clean vacuum relief valve filter. Check vacuum level and adjust. Inspect vacuum breaker for water leaks, Check collection tank drainage (if applicable), Oil change (for RamVac and other lubricated dry systems), Replace solids collector bowl, gasket & strainer.
Annually*	Amalgam Separator	Recycle solids collector
Annually*	Water System	Replace filter on whole system filtration systems
Annually*	Junction Box	Change air and water filters. Check that air pressure is between 80-100 & water pressure is 40psi.
Annually*	Sterilizer	Replace door gasket and chamber filters
5 – 10 Year or Manufacturer's Guidelines	Lead aprons	Replace lead aprons every 5 – 10 years, or according to Manufacturer's guidelines; Expiration date is to be written on tag of apron using permanent marker.
10 year cycle*	Dental Unit tubing	Schedule technician to have dental unit tubing replaced
Per Manufacturer's Guidelines	Portable Air Filtration Unit	Replace air filters for unit per manufacturer's guidance; replace with the highest level filtration recommended by manufacturer.
Per Manufacturer's Guidelines	HVAC Air Filter	Replace air filters for unit per manufacturer's guidance; replace with the highest level filtration recommended by manufacturer.
Per Manufacturer's Guidelines	Environmental Air Purifier System	Replace the air filters and/or UV lamps per manufacturer's guidance, aligning with the needs of the clinic.

* Performed by a service technician

Clinical Mandates

Item	Mandate
Immunizations	All staff will be responsible for the assessment of each child’s immunization status at every clinic visit. Patients who are not up-to-date on recommended immunizations should be referred to nursing personnel. Per PHN protocol and CHS Policy 3.07 “Immunizations Offered in Local Health Departments” – revised February 22, 2022
Dental Anesthetics	Anesthetic is to be kept behind locked cabinet/drawer/door when not in use. When in use by dental personnel, the anesthetic can be readily available.
Disinfecting Wipes/Solution	Use 1 minute disinfecting wipes and/or solution that is EPA approved
Face Shields	Closed at the top, to or below the chin, and to the ears
Face Masks	Clinical staff is to wear facemask with an ASTM (American Society of Testing and Materials) rating of Level 3 (high barrier) or higher during patient treatment
Gloves	Nitrile and surgical gloves are required for oral surgery and must be placed over the gown cuffs
Gowns	Long-sleeved, below the knee cuffed, back facing disposable gowns. Gowns must be changed between patients
Saliva Ejectors	One-way valve is to be used on all saliva ejectors; these items are single use/disposable or can be built into the saliva ejector housing

<p>Pediatric Blood Pressure Monitoring</p>	<p>Blood pressure should be measured annually in children and adolescents ≥ 3 years of age. Blood pressure should be measured at each visit for patients (including children) with a history of hypertension.</p> <p>PHN Protocol for BP children</p> <p>Clinical Practice Guideline for Screening and Management of High Blood Pressure in Children and Adolescents</p>
<p>Trashcans</p>	<p>Trashcans in work areas should be galvanized stainless steel or other non-corrosive metal container and have a closed lid</p>
<p>Soap/Sanitizer Dispensers</p>	<p>Utilize hands-free dispensers; if hands-free is not used, dispenser is to be disinfected after each use. Hand sanitizer should be 60-95% Alcohol</p>

Clinical Recommendations

Item	Recommendation
<p>High Volume Evacuation (HVE)</p>	<p>One-way valve is recommended on all high-volume evacuations (HVE); these items can be single use/disposable or when available can be built into the HVE housing</p>
<p>Plexiglass Splash Guards</p>	<p>Place splash guards in zones where any items could become contaminated.</p>
<p>Headcovers</p>	<p>Headcovers are recommended</p>
<p>Shoe Protectors</p>	<p>Shoe protectors or designated shoes are recommended</p>
<p>Continuing Education</p>	<p>Recommendation to utilize tool offered through TN Board of Dentistry; web-based CE tracking may be accessed HERE*</p>

Pediatric Screening Blood Pressure Values Requiring Further Evaluation

Age (years)	BP, mm Hg			
	Boys		Girls	
	Systolic	DBP	Systolic	DBP
1	98	52	98	54
2	100	55	101	58
3	101	58	102	60
4	102	60	103	62
5	103	63	104	64
6	105	66	105	67
7	106	68	106	68
8	107	69	107	69
9	107	70	108	71
10	108	72	109	72
11	110	74	111	74
12	113	75	114	75
13	120	80	120	80



Medications in Drug Room

- Medications in the drug room are for patients who are uninsured
- Charges are made on a sliding scale based on income
- Those who have TennCare or other 3rd party coverage should be provided a written prescription
- Prescriptions are to be called in or written for medications not covered or for a medication that is not on the formulary

SPORE TESTING

All clinics must use a spore testing system that returns same-day results

1. Completed weekly if instruments are run. (Do not perform test if there is no clinic)
2. Follow manufacturer's instructions.
3. Use a control vial each time a test is completed.
4. Conduct 3 consecutive spore tests if an autoclave is serviced, newly installed, or has a failed test.
5. Record results in Autoclave log.
6. Print a monthly log from the Attest [website](#) and include in the autoclave log book.
7. If a spore test result is positive, immediately notify regional dental director.

If a Spore Test Result is Positive

1. If the mechanical (e.g., time, temperature, pressure) and chemical (internal or external) indicators suggest that the sterilizer is functioning properly, a single positive spore test result probably does not indicate sterilizer malfunction.
2. Items other than implantable items do not necessarily need to be recalled; however, sterilizer operators should repeat the spore test immediately using the same cycle that produced the positive spore test.
3. To return autoclave to use, you must have 3 negative spore tests in three consecutive empty-chamber sterilization cycles.
4. When possible, items from suspect loads dating back to the last negative spore test should be recalled, rewrapped, and re-sterilized.
5. Results of biological monitoring and sterilization monitoring reports should be recorded.

WATER PROTOCOL

Run water through each handpiece and 3 way syringe 2 minutes at the beginning of each clinic session and 20-30 seconds between each patient.

Waterline Care and Maintenance

1. Follow manufacturer's instructions of device being used
2. Installation of DentaPure cartridge; ([Crosstex DentaPure DP365B Waterline Treatment Installation Video](#))
 - a) Shock dental unit waterlines with approved waterline agent **prior to initial installation** of DentaPure cartridge
 - b) Approved shocking agents: Citrisil, Vistatab, or Sterilex
 - c) Once cartridge is in place, water will pass through cartridge and is ready
3. Inspect cartridge each time water bottle is filled.
4. Empty water bottle and replace empty bottle back over DentaPure cartridge when dental unit is not in use
5. Test each waterline every 6 months
6. Document waterline testing on the waterline log
7. Dentapure 365 cartridge should be replaced at least every 12 months
8. Maintain results for 2 years
9. If a test fails, retest lines that have failed ASAP and immediately notify regional dental director.
10. DentaPure cartridge on a dental unit that has been out of service and/or in storage for a period of time, follow these instructions for re-installing a DentaPure cartridge

PRIOR to STORAGE

- a) Remove cartridge and place in airtight plastic bag with original installation date on bag

PLACING UNIT back in USE

- a) Follow manufacturer's instructions for preparing unit and perform a shock PRIOR to re-installing cartridge
- b) Re-install cartridge
- c) Discontinue use of all DentaPure cartridges after one year from installation date.
NOTE: if unit will be vacant, not in use for greater than two weeks but still in service, daily flushing is recommended. If staff are not available to flush daily, extended flushing protocols should be considered on the days that staff are available; flushing the unit multiple times a day for example.

[Click here](#) for access to DentaPure Instructions for use.

Distilled and Sterile Water Usage

I. Sterile water

- a. Sterile water should be used for irrigation in oral surgery
- b. Sterile water should be discarded after opening

II. Distilled water

- a. Distilled water should be purchased in pre-sealed containers
- b. Once opened, date should be placed on the outside of container
- c. Distilled water should be used or disposed of within 30 days of opening
- d. Distilled water should be used for all autoclaves
- e. Distilled water should be used in self-contained water bottles on each chair

Autoclave Usage and Maintenance

USAGE

1. Autoclave should be operated per manufacturer's guidelines.
2. Inspect seals and chamber prior to use.
3. Insure the water level is correct.
4. Use only distilled water.(See water protocol guidelines)
5. Drain water weekly and discard drained water.
6. Package items to be sterilized.
7. Clean and heat sterilize intraoral devices that can be removed from air and waterlines, including all handpieces, motors and attachments.
8. Do not overload chamber/ cassette.
9. Run cycle.
10. Allow instruments to dry.
11. Store in cabinets or covered containers.
12. **Package protocol** – Use date shelf life practices
 - a. Prior to sterilization packaged instruments must be labeled appropriately:
 - b. Use an autoclave label, autoclave tape, or follow sterilization pouch manufacturer's instructions for documenting on package.
 - c. Date of sterilization (month, day and year) and load number on each pouch.
 - d. If more than one autoclave on site, must mark on each pouch which autoclave was used.
 - e. Use **black** medical grade marker or approved Sharpie (Sharpie brand markers with a circled AP are acceptable.)
 - f. Use pouches or tape with a steam indicator on packaging.
 - g. Internal and external indicators must be used in and on each pouch.
 - h. Don't overfill the pouches. Leave 1 inch of space on all sides of instruments and only fill to 75% capacity of pouch.
 - i. Unpackaged items should be used immediately after sterilization.
 - j. Inspect packages prior to storing. When packaging of sterile items is damaged, re-clean, re-wrap, and re-sterilize.
 - k. Re-wrap and re-sterilize any stored items that have been autoclaved longer than one calendar year.
 - l. Rubberbands should not be used on processed items.

13. **Sterilization monitoring**

- a. Mechanical
 - 1. Measure time, temperature, pressure
 - 2. Observe gauges/displays on the sterilizer
- b. Chemical
 - 1. Chemicals change color when parameter is reached
 - 2. Must be an internal indicator within all packages
- c. Biological
 - 1. Biological spores are used to assess sterilization
 - 2. Spore test logs should be kept for 2 years

14. TDH Policy- Transportation of non-sterile autoclavable dental instruments is not permitted.

DIGITAL RADIOGRAPHY

SCAN-X READER

1. Follow Manufacturer's instructions.
2. Keep server and Scan-X in a clean- cool environment.
3. Cover the Scan-X reader during periods of non-use.

SCAN-X PLATES

1. Keep imaging plates organized and ready for use.
2. Always use barrier sleeves for the imaging plates.
3. Inspect plates daily for signs of damage.
4. Replace plates as needed.

Daily considerations:

1. Leave the computer running at all times.
2. Log in to the server computer each morning and log out at the end of each day
3. Open Patterson imaging
4. Take radiographs per manufacturers recommendations and training
5. End of the day- back up images per regional protocol

Digital Sensors

1. Secure the sensors to prevent damage from falls in between use
2. Follow manufacturer's guidance use, storage, and disinfection.
3. Ensure no twisting, wrapping, or knotting of cords.

General considerations:

1. Images are a component of protected health information.
2. All images need to be labeled (tooth number and/or area) and oriented correctly.
3. Use secure email protocol to transfer images outside of the State email network.
4. Run the disposable cleaning sheets through the scanner weekly, per manufacturer instructions.

REFRIGERATORS IN DENTAL CLINICS

- Refrigerators in dental clinics should be clearly marked for their purpose. If dental materials are stored in a refrigerator, no food should be stored in the same refrigerator.
- There will be a sign on the outside of all refrigerators in dental clinics noting contents as “Dental Supplies Only” or “Staff use only. NO dental supplies”

HIPAA Compliance: Sending a Secure Email

Using the secure email format is important when sending confidential HIPAA information. If an unintended recipient intercepts a secure email, the email will be unreadable, and essentially useless.

How to Send a Secure Email:

Staff (the sender) should include the heading, **[Secure Email]**, including the square brackets, in the subject line of the email. Other information can be in the subject line as long as the [secure email] is in brackets. For example: Patient Referral Log [Secure Email].

If the recipient is an outside party (meaning they **do not** work for the State of TN), the following will occur:

- Exchange users send email with [Secure Email] in the subject line, including the square brackets.
- The E-Mail system examines the subject line to determine that encryption is required.
- The message is routed to the Office 365 Secure Email.
- A notification is created and sent to the recipient.
- The recipient is required to retrieve the message via a web browser. The recipient has the option to reply securely.

NITROUS OXIDE WORK PRACTICES

<https://www.osha.gov/dts/osta/anestheticgases/>

Work Practices

- Prior to first use each day of the N₂O machine and every time a gas cylinder is changed, the low-pressure connections should be tested for leaks. High-pressure line connections should be tested for leaks quarterly. A soap solution may be used to test for leaks at connections. Alternatively, a portable infrared spectrophotometer can be used to detect an insidious leak.
- Prior to first use each day, inspect all N₂O equipment (e.g., reservoir bag, tubing, mask, connectors) for worn parts, cracks, holes, or tears. Replace as necessary.
- Connect mask to the tubing and turn on vacuum pump. Verify appropriate flow rate (i.e., up to 45 L/min or manufacturer's recommendations).
- A properly sized mask should be selected and placed on the patient. A good, comfortable fit should be ensured. The reservoir (breathing) bag should not be over- or underinflated while the patient is breathing oxygen (before administering N₂O).
- Encourage the patient to minimize talking, mouth breathing, and facial movement while the mask is in place.
- During N₂O administration, the reservoir bag should be periodically inspected for changes in tidal volume, and the vacuum flow rate should be verified.
- On completing anesthetic administration and before removing the mask, non-anesthetic gases/agents should be delivered to the patient for a sufficient time based on clinical assessment that may vary from patient to patient. In this way, both the patient and the system will be purged of residual N₂O. Do not use an oxygen flush.
- Nitrous oxide use will require autoclavable or disposable masks and tubing that will be autoclaved or changed out between patients.

Silver Diamine Fluoride (SDF)

Prior to Application

1. Educate patient, parent, or guardian

- a. Benefits of treatment (kills bacteria, stops decay, might prevent extensive work)
- b. Clinical effects (dark staining of lesions - show pictures of examples)
- c. Procedure should be repeated in approximately 2 weeks
- d. Restorations not to be placed less than 4 weeks after application

2. Obtain consent in writing – per treatment phase

- a. English (PH 4300) created 09/01/16
- b. Spanish (PH 4300S) created 09/01/16

3. Contraindications

- a. Silver allergy or sensitivity
- b. Ulcerative gingivitis or stomatitis
- c. Teeth with evidence of pulpitis or pulpal necrosis are not appropriate for SDF treatment and require surgical treatment.

Application

Within TDH Dental Clinics, RDAs can apply under direct supervision and after completing required training and completion of competency checklist

1. Apply SDF

- a. Do not excavate. Teeth with deep lesions where the carious dentin has been excavated are not candidates for SDF, due to the ammonia content and high pH which may create a pulpal reaction.
- b. Apply no more than 1 drop/ 10kg (22lbs) of weight
- c. Protect patient's eyes and use caution to avoid contact with skin or clothing
- d. Air dry and isolate teeth with cotton rolls and mask with petroleum jelly as appropriate.
- e. For up to 5 treated sites per patient, dispense 1 drop of solution into a disposable dappen dish
- f. Transfer the material directly to the tooth surface with an applicator
- g. Wait and keep isolated for approximately one minute to allow SDF to soak into and react with the lesion
- h. Wipe away excess SDF with isolating cotton rolls
- i. Repeat as needed (2 applications per site are recommended with 2 week interval)

2. Post-operative instructions

- a. The affected area will permanently turn black
- b. You might have a metallic taste in your mouth, however, this will quickly go away
- c. If decay is not arrested after the second application, the progress of the decay will continue. This may lead to the need for additional treatments, such as repeating the SDF, a filling, crown, root canal treatment or extraction.

3. Coding

- a. D1354 – Interim Caries Arresting Med. Application
- b. Code per tooth application – Enter each tooth number on the encounter**

Follow up

- a. Recommend 2 applications per site. Clinical evidence supports continued application 1-2 times per year until the tooth is restored or exfoliates.

For more information please reference the ASTDD Silver Diamine Fluoride (SDF) Fact Sheet March 2017 Amended July 2017.

Silver Diamine Fluoride (SDF) Fact Sheet

March 2017 Amended July 2017

What is SDF?

Silver diamine fluoride (SDF) has been used extensively outside the United States for many years for caries control.¹ SDF is a colorless liquid containing silver particles and 38% (44,800 ppm) fluoride ion that at pH 10 is 25% silver, 8% ammonia, 5% fluoride, and 62% water. This is referred to as 38% SDF.

What is the strength of evidence for SDF?

In clinical trials, SDF applied directly to the cavitated lesion outperformed fluoride varnish for the non-surgical arrest of caries in children and older adults. In addition, SDF demonstrated impressive caries prevention to adjoining teeth not receiving direct application of SDF.^{1,2} At least eight published reports of randomized clinical trials consistently demonstrated very high rates of caries arrest.^{3,4,5,6,7,8,9,10} Although a 2016 systematic review and meta-analysis of clinical trials in children concluded 38% SDF applied at least once per year effectively arrested more than 65% of active caries,¹¹ there is no consensus for the number and frequency of applications for optimal caries control.¹² A critical summary of the systematic review, published in early 2017, called for more well-designed and well-conducted clinical trials comparing the effectiveness of SDF with no treatment or other caries management approaches in populations with varying caries risk, lesion severities, and other fluoride exposures.¹²

Does SDF have FDA Approval?

In August 2014, SDF was cleared by the Food and Drug Administration (FDA) as a desensitizing agent, similar to fluoride varnish 20 years ago.¹³ As of early 2017, there is only one SDF product on the U.S. market. The FDA granted the manufacturer “breakthrough therapy status,” facilitating clinical trials of SDF for caries arrest. It is used off-label for caries arrest.

What are indications for SDF use?

SDF arrests active carious lesions painlessly and without local anesthetic, as long as the teeth are asymptomatic, avoiding or delaying traditional surgical removal of caries. This intervention can be applied to teeth as soon as caries is detected. SDF is indicated in treating caries in people who are unable to access dental treatment or tolerate conventional dental care, including very young “pre-cooperative” children, persons with intellectual/developmental disabilities, or older adults.

What are contraindications for SDF therapy?

No adverse events using silver compounds have been reported in more than 80 years of use in dentistry.^{1,14} Silver allergy is the only known contraindication.² Teeth with evidence of pulpitis or pulpal necrosis are not appropriate for SDF treatment and require surgical treatment. Similarly, teeth with deep lesions where the carious dentin has been excavated are not candidates for SDF, due to the ammonia content and high pH, which may create a pulpal reaction.

Are there other considerations for SDF therapy?

The silver particles in SDF darken active dental caries and if touched, temporarily stain unprotected soft tissues, which may be a concern with patient/parent acceptance. It does not stain sound enamel. See the UCSF protocol (below) for additional information. Some individuals report a transient metallic taste after application of SDF. SDF will also permanently stain floors, clothing, and furniture.

Are there recommended protocols?

All providers applying SDF need appropriate training. In January 2016, for example, the University of California San Francisco (UCSF) School of Dentistry published a thorough [clinical protocol](#) for the use of SDF¹⁴ (watch the [application](#) of SDF on YouTube). The American Academy of Pediatric Dentistry is currently conducting a review and, depending on the evidence, may include clinical guidelines (personal communication, Norman Tinanoff, University of Maryland, 3/1/2017).



Pit and Fissure Caries



Pit and Fissures w/ SDF
Photos Courtesy Steve Duffin



Caries-Before SDF



After SDF
Photos: Pediatric Dentistry V 38:
No 3, May/June 2016

Environmental Air Purifier Systems

VidaShield Air Purifier System is a UVC (ultraviolet), continuous antimicrobial environmental air purifier system. It combines an ultraviolet germicidal irradiation chamber and air circulating fans with an overhead ceiling light.

[VidaShield Installation and Operating Instructions](#)

VidaShield UV Maintenance:

1. The VidaShield unit should run 15-30 minutes before the first patient of the day and 15-30 minutes after the last patient of the day, for a normal size operatory
2. The indicator light on the unit should be checked at the end of each day's use to confirm it is working properly
3. Once the VidaShield unit is turned off, the indicator light should only illuminate for a short moment
4. If the indicator light is illuminated in a continuous manner once the unit is turned off, the UV lamp will need to be replaced
5. To assure that the UV lamp in each unit works as expected, change as recommended:
 - a. Units wired to run during clinic hours: UV lamps should be replaced every 2 yrs.
 - b. Units wired to run constantly: UV lamps should be replaced annually
6. The UV lamps are special for these units, for replacement please contact the VidaShield distributor or factory for replacement lamps; 800-831-1222 or online at www.vidashield.com
7. The UV lamps (blubs) should be recycled per EPA guidelines <https://www.lamprecycle.org/>

VidaShield MERV 6 Filter Maintenance:

1. To assure the filter in each unit works as expected, change as recommended:
 - a. Units wired to run during clinic hours: filters should be changed every 6 months
 - b. Units wired to run constantly: filters should be changed every 3 months
2. The filters are special for these units, for replacement please contact the VidaShield distributor or factory for replacement lamps; 800-831-1222 or online at www.vidashield.com

Surgically Clean Air Jade has HEPA-Rx Filter (remove particles), Activated Carbon Filter (absorbs odors and gases), Germicidal UV-C+ and Super Oxidizing Photocatalytic Nano-TiO₂ system (killing airborne pathogen) and two Revitalizing Negative Ion generators (revitalize and refresh the air). The unit can be operated with the wave of the hand.

[Surgically Clean Air Jade Operation Manual](#)

Surgically Clean Air Jade Maintenance:

1. To maintain optimum performance, the filters and UV blub need to be replaced when indicator lights are flashing: Green=Good, Orange=Unhealthy, Red=Hazardous
2. In atmosphere with heavy dust, periodically vacuum the filters for optimal performance
3. Wipe with a dry cloth for stubborn stains or dirt
4. Do not use volatile fluids or detergents as this may damage the unit
5. Keep the unit away from water
6. Due to not running the unit 24/7 in the clinic, the recommended maintenance:
 - a. HEPA Filter: change every 2 years
 - b. Carbon filter (2 per unit): change every 6 months
 - c. UV lights: change every 2 years
7. The filters and UV lights are special for these units, for replacement please contact Surgically Clean Air
8. The UV lights (bulbs) should be recycled per EPA guidelines
<https://www.lamprecycle.org/>