General Information

Oral Diagnosis & Radiology
HELPFUL INFORMATION

- **SHOW UP** every clinic period and do not waste valuable clinic time!

- If you and/or your patient are late (more than 15 minutes), and you have not addressed faculty about the problem, your chair may be given to another student, either in OD Clinic or OD Workup Clinic.

- Fall semester of your sophomore year is your only opportunity to work in clinic simultaneously with Oral Diagnosis, Perio, Operative, and Occlusion faculty. **You should take advantage of their presence and get several work-ups completed.**

- You must have the soft tissue (head and neck) exam sheet reviewed by OD faculty *before* using any disclosing solution in your patient’s mouth.

- Grade sheets for the various departments as well as chart forms are located in most laboratory areas.

- Please ask faculty questions *after* you have thoroughly referenced this clinical instruction guide.

- All progress notes are to be completed with blue or black ink pen. All charting is done using a red/ blue pencil and all unnecessary markings or mistakes on the charting should be initialed and dated. Do not erase any chart entries.

- The radiographic interpretation on the Oral Diagnosis Clinical Procedure Assessment form is to be graded by the Oral Diagnosis faculty, who evaluates your hard tissue charting. You should be prepared to discuss findings (interproximal caries, bone loss, periapical radiolucencies, etc).

- When creating a Master Treatment Plan for a patient that needs extractions, you will need to specify whether the extractions are routine and can be done in the student clinic. If not, they are referred to the resident clinic and “OS TBD” is recorded on the MTP.

- **Do Not** handle charts with contaminated gloves! Remove gloves or use over-gloves. **No Exceptions!** This is considered a breach in aseptic technique and will adversely affect your final work-up grade.

- Routing sequence always begins with Perio first, followed by Occlusion, and Operative departments.

- **Do Not Use** chair time to do clinical radiographic findings.
GRADE SHEETS

An explanation of the grading scale for Oral Diagnosis and Radiology clinical grades may be found at the department website (w3.ouhsc.edu/oral-diagnosis-radiology).

O.D. WORKUP CREDIT FOR PREVIOUSLY ASSIGNED PATIENTS

Not infrequently, dental students are assigned patients who have already been seen by dental hygiene students. In those cases, the dental hygiene student has already completed the health history, head and neck examination and charting. Dental students should review these specific areas, but will not receive a grade on the work-up evaluation form for each of these areas. Instead, a not applicable (NA) will be inserted. This only applies to patients seen by a dental hygiene student within the last six months. If a student is assigned a patient in which the health history, head and neck examinations and charting were done by a hygienist or a dental student more than six months ago, they will need to redo those procedures and will receive a grade.

REQUIRED FACULTY SIGNATURES

The student is responsible for obtaining faculty signatures for their workup procedure in Oral Diagnosis and Radiology in the following places:

1. Permission to Proceed
2. Summary of History
3. Medical Alert Page
4. Progress Notes
5. Signature For Radiographs
6. Clinical Examination, Record of Existing Oral Conditions, Radiographic Interpretation, Diagnoses, Tentative Treatment Plan
7. Routing
8. Evaluation Form (Grade Sheet)
MASTER TREATMENT PLAN APPROVAL PROCESS

New Master Treatment Plans: When you are ready to submit your Master Treatment Plan Worksheet for entry in Quick Recovery, take the chart with your OD grade slip and worksheet along with a completed Chart Task form to Linda Hale’s office, Room 239. Place the chart in the slot outside the door. The information will be entered in Quick Recovery and the chart forwarded to Oral Diagnosis once it is complete.

Oral Diagnosis will print a copy of the Master Treatment Plan once the department has received the chart and forward it to the appropriate instructor for review and approval.

MTP’s totaling less than $1200 will be printed, signed by approving OD faculty, placed in the patient’s chart and returned to the records room. It is your responsibility to sign and have the patient sign the MTP at the next appointment.

MTP’s totaling more than $1200 will be printed, signed by approving OD faculty, placed in the patient’s chart and given to Tracy King in the Central Business Office. You are responsible for scheduling a time for the patient with Tracy King for a financial meeting. At this meeting, the patient will be asked to sign the MTP. It is recommended that you be present for the financial meeting to have a clear understanding of the financial expectations associated with your patient’s MTP.

Please e-mail Tracy King and Tammy Vogt to notify them of the date and time of your patient’s next appointment so the staff will be prepared for your patient’s arrival.

Before your patient’s next appointment, direct your patient to please see one of the financial representatives before clinic to have him/her sign the revised MTP. Instruct your patient to arrive 15-30 minutes earlier than clinic time for the financial meeting and to sign the MTP revision.

Revisions to Existing Master Treatment Plans: If additions or changes to an existing treatment plan are needed, fill out a MTP Revision Form with the needed changes, have it signed by appropriate department faculty and submit it with a Chart Task Form to Linda Hale’s office. Once the changes have been made, your MTP revision form will be forwarded to the Central Business Office for financial review.
EVALUATION PENALTIES, WORKUP FAILURES, OR ZERO GRADES

The following incidents may warrant a grade penalty, failing grade or zero grade for a workup, competency exam, or Oral Diagnosis and Radiology rotation. Please note that incidents which may result in a failing grade are not limited to the following list. A student wishing to appeal a failing grade must consult the current OUCOD Student Handbook and follow policy therein. However, a first step is to consult the Course Director, and then the Department Chair if necessary.

DS2 Clinical Course Director:  Dr. Panza
DS3 Clinical Course Director & Dept. Chair:  Dr. Settle
DS4 Clinical Course Director:  Dr. Beavers

- Failure to complete a workup in a timely manner (generally 1-2 months maximum) unless documented in the patient record that there are extenuating circumstances regarding the inability of the patient to be present in clinic
- Gross or multiple cross-contamination incidents or other infractions involving the guidelines in the Health and Safety Manual (located in the Clinic Policies Manual)
- Failure to obtain (Permission To Proceed) PTP prior to beginning treatment
- Failure to complete a health history and obtain a faculty signature prior to taking radiographs or conducting oral examinations
- Failure to complete the MEDICAL ALERT page
- Initiating treatment without proper antibiotic prophylaxis when indicated
- Gross errors in communication with faculty, staff or your patient; this includes leaving OD clinic when on your rotation
- Placing student needs (requirements) above those of the patient. This includes proceeding with treatment without a Master Treatment Plan (MTP) approved and signed by Oral Diagnosis faculty
- Gross infractions of the OUCOD Clinic Policy Manual
- Multiple errors on Master Treatment Plan or MTP Worksheet
Health History Summary - How to write in a paragraph form.

1. **Include patient's age, sex, race, and general statement of health and CC (Chief Complaint and history of CC).** Ex: Patient presents as a 50-yr. old black male in no apparent distress with a CC of "my gums are tender and bleeding for one month." Or if no CC, can write with no CC. For general health, may include the word obese, appears anxious, nervous, SOB (short of breath), NAD- no apparent distress, WDWN- well developed, well nourished.

2. **History of disease** - PMH or PMHx (past medical history of disease). Patient reports a history of diabetes, etc. Report current and past diseases. Surgical Hx should be included in this section if the patient reports a history of any type of surgery. If patient reports no histories of diseases or surgeries, then write PMH is negative in the summary statement. Need to determine if patient’s medical history is stable for dental treatment or is a medical consult needed prior to treatment.

3. **Current medications** - Patient reports a history of Type 2 diabetes diagnosed at age 42 for which he takes drug & dosage. Pt. (patient) also reports taking (list all drugs and dosages including OTC (over the counter), or any herbal supplements in this section. List any antibiotic premedication taken or needed by the pt.

4. **Allergies** - List all drug allergies, latex allergies, and any food allergies (nuts, shellfish, etc). If no allergies present, state that pt reports no drug allergies (NKDA).

5. **Family history** - Report any family history that might be contributory. Such as diabetes, cardiovascular problems, cancer, bleeding disorders, stroke (CVA), hypertension. List maternal or paternal side. If family history is noncontributory then record in the chart.

6. **Personal history /Social History** - Include pt's oral hygiene, habits, and diet information. EX: Pt brushes 3 x day, flosses 1 x day. Pt. reports no history of tobacco, or alcohol use, and has a low dietary sugar intake.

Example of a Health History Summary:
Patient is a 50 yr. old black male is WDWN with a CC of “my gums are tender and bleeding for one month.” PMHx: Type 2 diabetes diagnosed at age 42. Surgical Hx: includes surgery to remove his gall bladder in 1998 with no post-op complications. Current meds are Glucophage 500 mg bid for diabetes. Pt reports NKDA. Family history is contributory for father who died from a heart attack at age 76 in 1994 and mother died from a stroke in 1999. Pt. reports brushing his teeth once a day and does not floss. He also reports that he does not smoke or drink alcohol, and has a low dietary sugar intake. Patient’s medical condition is stable for dental treatment.
Oral Diagnosis
Charting Key for “Record of Existing Oral Conditions”

1. Chart all conditions that are detectable by clinical examination and/or radiographic examination in red or blue pencil. Existing normal (healthy) conditions in blue; existing abnormal (unhealthy) conditions in red.

2. Mark all missing teeth not replaced by fixed prosthesis with a blue “X” through the entire tooth including occlusal, lingual, buccal and root views.

3. Circle impacted or unerupted teeth in blue pencil. Include all views in the circle and place a large blue arrow within the circle indicating the long axis of the tooth and where the crown is pointing.

4. Outline every restoration in blue according to its outline or margins as you view it clinically from the occlusal, buccal, or lingual surfaces.

5. Fill in the interior blue outline of any amalgam restoration solidly in blue pencil.

6. Leave the interior of the blue outline of any “white or tooth-colored restoration” clear. Label the type of restoration, (composite, temporary filling,) in the “Other Findings” space. Label sealants with “S” on the occlusal surface view.

7. Outline every crown in blue according to its outline or margins as you view it clinically from the occlusal, buccal, or lingual surfaces.

8. Fill in the interior of any gold restoration or non-precious metal (gold inlay, FGC, gold foil, SSC) with slanting blue parallel lines. Label in Other Findings.

9. Fill in the interior of any part of a crown which is gold with blue slanting parallel lines; leave any “white or tooth colored” part of the crown with only the blue outline, (MCR). For porcelain or ceramic type crowns outline in blue only, since there isn’t any metal coping inside the crown.

10. If a tooth is missing and replaced by a fixed bridge, draw a “X” through the buccal and lingual root views only in blue. Draw the pontic in the same manner as a crown. Connect the abutments and the pontic with parallel lines at the occlusal view (for posterior bridges) and the lingual
view (for anterior bridges). Mark the connecting parallel lines according to the material used in the bridge.

11. Mark any root canal fillings in blue as they appear radiographically on the buccal view only. Also draw and label the access restoration material used for the tooth.

12. For a dental implant, draw a blue rectangle with slanting blue parallel lines to indicate metal on the root surface of the tooth on the buccal view only.

13. Draw open contacts with two blue parallel lines between the two teeth and extending the lines through all three views of the tooth. Measure and note the width of the diastema to the closest millimeter. Record this measurement on the buccal view only.

14. Mark drifted or repositioned teeth with two blue arrows, on the buccal and lingual views indicating the new position of the tooth. For extruded teeth or unusual drifting, make a statement about it in the “Other Findings” space.

15. Mark rotated teeth with a red arrow in the direction of the rotation around the occlusal view only.

16. Draw an overhang on the buccal view only as an extension in blue pencil of your drawing of the restoration exactly as it appears either clinically or radiographically. Circle the blue overhang in red pencil.

17. Mark carious lesions in red pencil as they appear clinically. If a lesion is seen interproximally on a radiograph only, then draw the lesion as a chevron (>) on the buccal view of the tooth only.

18. Draw open or carious margins of restorations in red pencil where you see them on the tooth.

19. Draw any periapical radiolucency as it appears on the radiograph and color in solidly in red pencil on the buccal view only.

20. Outline any other pathology seen radiographically in red, identify it with a number within or near your outline and describe the lesion in “Other Findings” prefixed by your identifying number.
21. Draw fractured, missing parts of a tooth with a red line along the fracture site.

22. Fractured or missing parts of a tooth that have become carious on the fracture site would be colored in solid red pencil.

23. Indicate excessive wear, abrasion, or any condition localized to individual teeth in the “Other Findings” space.

24. For generalized conditions, use the space marked “Comments” at the bottom of the page.

25. Draw abnormal gingival architecture as accurately as possible with detail to clefts, recession, and the interproximal contour, using the red pencil. Do not draw normal gingival contour. Draw a line indicating the mucogingival junction in blue pencil on the root surface, the proper distance from the CEJ and the free gingival margin in these areas of abnormal gingival architecture only. Remember, the lines on the root surface views indicate 2 mm increments.

26. Mark clinical furcation findings with an open triangle (^) in the furcal area and record the extent of furcation involvement with the Arabic number 1, 2, 3, 4 under the open triangle.

27. Mark high muscular frenum attachment in the approximate location with a “v” shaped line in red pencil.

28. Write in areas of food impaction on the slanted lines indicating “Other Findings”.

29. Mark mobility in Roman Numerals (I, II, III) on the buccal view of the crown of the tooth in red pencil.

30. Record all sulcular depths of 1-3 mm in the appropriate space in blue pencil. Record sulcular measurements 4 mm or greater in red pencil. Circle the corresponding probing depths of any bleeding points in red pencil.

31. Indicate any exudates, food impactions, etc. in “Other Findings.”
32. Classify the occlusion according to Angle’s system and record in the “Comments” section. Also record Overjet, Overbite, Open bite, and Crossbites in the “Comments” section.

33. Do not mark any treatment suggestions on this charting form, e.g. do not mark teeth to be extracted with two vertical parallel blue lines.
# Charting Key for Record of Existing Oral Conditions Example

**Tooth #**

<table>
<thead>
<tr>
<th>Tooth #</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>Missing tooth</td>
</tr>
<tr>
<td>#2</td>
<td>OL amalgam</td>
</tr>
<tr>
<td>#3</td>
<td>FGC (full gold crown) with RCT (root canal therapy)</td>
</tr>
<tr>
<td>#4</td>
<td>O with IRM temporary restoration</td>
</tr>
<tr>
<td>#5</td>
<td>F composite with distal rotation</td>
</tr>
<tr>
<td>#6</td>
<td>2mm of facial abrasion and 8mm at mucogingival junction</td>
</tr>
<tr>
<td>#7</td>
<td>L composite with RCT</td>
</tr>
<tr>
<td>#8</td>
<td>3-unit MCR (metal ceramic restoration) bridge abutment</td>
</tr>
<tr>
<td>#9</td>
<td>Missing tooth and MCR pontic for 3-unit bridge</td>
</tr>
<tr>
<td>#10</td>
<td>3-unit MCR bridge abutment</td>
</tr>
<tr>
<td>#11</td>
<td>Fractured &amp; missing MIFL portion of tooth</td>
</tr>
<tr>
<td>#12</td>
<td>O sealant</td>
</tr>
<tr>
<td>#13</td>
<td>O &amp; F caries</td>
</tr>
<tr>
<td>#14</td>
<td>Implant with MCR crown</td>
</tr>
<tr>
<td>#15</td>
<td>MO amalgam with mesial overhang</td>
</tr>
<tr>
<td>#16</td>
<td>All surfaces (MODBL) of tooth is carious and missing, only root tips left</td>
</tr>
<tr>
<td>#17</td>
<td>O amalgam with recurrent caries and mesial drift</td>
</tr>
<tr>
<td>#18</td>
<td>Missing tooth</td>
</tr>
<tr>
<td>#19</td>
<td>Fractured and carious missing MOB cusp. Probing depths with bleeding points and food impaction.</td>
</tr>
<tr>
<td>#20</td>
<td>M &amp; D radiographic caries</td>
</tr>
<tr>
<td>#21</td>
<td>Class II mobility and periapical lesion.</td>
</tr>
<tr>
<td>#22</td>
<td>Incisal attrition</td>
</tr>
<tr>
<td>#23</td>
<td>ML composite with Incisal attrition</td>
</tr>
<tr>
<td>#24 &amp; 25</td>
<td>2mm diastema with Incisal attrition</td>
</tr>
<tr>
<td>#26</td>
<td>MFL composite with Incisal attrition</td>
</tr>
<tr>
<td>#27</td>
<td>Incisal attrition</td>
</tr>
<tr>
<td>#29</td>
<td>3-unit FGC bridge abutment</td>
</tr>
<tr>
<td>#30</td>
<td>Missing tooth and FGC pontic for 3-unit bridge</td>
</tr>
<tr>
<td>#31</td>
<td>3-unit FGC bridge abutment</td>
</tr>
<tr>
<td>#32</td>
<td>Impacted with mesial horizontal angulation</td>
</tr>
</tbody>
</table>

**Occlusion:** MB Cusp of maxillary 1\textsuperscript{st} permanent molars occludes with the buccal groove of the mandibular 1\textsuperscript{st} permanent molars.
MEDICAL ALERT

The following conditions may warrant a Medical Alert sticker placed on the upper left corner of a patient’s chart. These conditions include but are not limited to the following:

ADRENAL CORTEX DISORDERS
Addison’s Disease
Cushing’s Syndrome
Adrenal Insufficiency- Exogenous Steroids

ALLERGIES
Drug Allergies
Dental Material Allergies
Latex Allergy

CARCINOMA HISTORY
Type
Surgery
Chemotherapy
Head and Neck Radiation

CARDIOVASCULAR CONDITIONS
Angina
Arrhythmias
Coronary Bypass Surgery
Cerebral Vascular Accident (Stroke)
Hypertension
Murmur
Myocardial Infarction
Prosthetic Valve
Rheumatic Heart Disease

DIABETES

GASTROINTESTINAL
Irritable Bowel Disease (IBD): Crohn’s; Ulcerative Colitis
Peptic Ulcer Disease
Gastroesophageal Reflux Disease (GERD)
Irritable Bowel Syndrome (IBS)
HEMATOLOGIC DISORDERS
Anemias
Coagulation Disorders
Leukemia
Lymphomas

HISTORY OF BISPHOSPHONATES
Fosamax
Boniva
Actonel
Reclast (IV)
Zometa (IV)
Aredia (IV)

INFECTIOUS DISEASES
HIV-AIDS
Infective Endocarditis
Tuberculosis
Viral Hepatitis

LIVER DISEASE
Hepatitis
Cirrhosis
Carcinoma

MEDICATIONS
Medications that are taken for a medical condition and may modify dental treatment.
Anticoagulants- Warfarin (Coumadin)
Corticosteroids
Lithium
Non-selective beta blockers- Blocadren, Corgard, Inderal, Propranolol, Timolol
Tegretol (Carbamazepine), Nizoral (Ketoconazole), Theophylline
Tricyclic antidepressants- Amitriptyline, Anafranil, Elavil, Imipramine, Pamelor, Tofranil
Oral Contraceptives

MUSCULOSKELETAL & CONNECTIVE TISSUE DISEASES
Fibromyalgia
Rheumatoid Arthritis
Osteoarthritis
Scleroderma
Sjögren’s Disease
Systemic Lupus Erythematosus
NEUROLOGICAL DISORDERS
  Multiple Sclerosis
  Parkinson’s Disease
  Seizure Disorders

ORGAN TRANSPLANTATION

PSYCHIATRIC & BEHAVIORAL DISORDERS
  Depression
  Bipolar Disorder
  Schizophrenia

REACTIONS TO LOCAL ANESTHETICS

RENAI DISEASE/ DIALYSIS

RESPIRATORY DISEASES
  Asthma
  COPD (Chronic Bronchitis & Emphysema)

SICKLE CELL ANEMIA

SUBSTANCE ABUSE HISTORY
ORAL DIAGNOSIS

GUIDELINES FOR CONSULTATION LETTERS

Create a rough draft using these guidelines and save a copy in your word processing program. Have Oral Diagnosis faculty (preferably the faculty member who either saw the patient or is familiar with the circumstances of the referral) proof-read your copy and make any suggestions. Make the appropriate changes and bring the letter to the OD department Secretary, Andie Stringfellow, who will fax the letter to the physician’s office. You must have the fax number for the physician’s office available; we will not look it up for you. Return faxes will be placed in your mailbox.

First Paragraph- Introduction
• Introduction of yourself (Joe Smith, Second Year dental student @ OUCOD)
• Patient’s name
• Patient’s reported medical diagnosis and known current medications or…
• The reason for the referral and pertinent information regarding your request.

Second Paragraph- Information
• Brief description of dental therapy to be performed
• Type of local anesthetic to be used with percentage and type of vasoconstrictor
• Any medications you plan to prescribe
• Include the American Heart Association endocarditis prophylaxis regimen if appropriate, and cite a reference to the Journal of the American Dental Association (JADA): Prevention of Infective Endocarditis: Guidelines from the American Heart Association (June, 2007)

Third Paragraph- Questions
• Specific questions you have regarding the patient’s current health status, e.g., confirmation of a hip replacement within the last two years or other medical condition.
• Request for appropriate lab reports.
• Request for information or suggestions regarding delivery of dental care that the physician may feel is significant.

Request for Reply
• Send to: Susan L. Settle, D.D.S.
  Department of Oral Diagnosis and Radiology
  University of Oklahoma College of Dentistry
  1201 N. Stonewall Avenue
  Oklahoma City, OK 73117Fax: 405-271-3158
Complimentary Close and Signature

• Sincerely, OR…
• Respectfully yours
• Joe Smith, Second Year Dental Student