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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **3B. Medico-legal and Patient Care** | | | **Dentist name** | | | **Dentist name** | | | **Dentist name** | | | **Dentist name** | | | **Dentist name** | | | **Dentist name** | | | |
| Patient dental records\* demonstrate recording of: | | |  | | |  | | |  | | |  | | |  | | |  | | | |
| Pt 1 | Pt 2 | Pt 3 | Pt 1 | Pt 2 | Pt 3 | Pt 1 | Pt 2 | Pt 3 | Pt 1 | Pt 2 | Pt 3 | Pt 1 | Pt 2 | Pt 3 | Pt 1 | Pt 2 | Pt 3 | |
| 1 | A | * medical history updated at every recall and as appropriate………………………. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |
| 2 | A | * charting of missing/present teeth............ |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |
| 3 | B | * charting of existing restorations………… |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |
| 4 | A | * soft tissue examination………………….. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |
| 5 | A | * basic periodontal examination and/or periodontal charting recorded where appropriate ..……………………………… |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |
| 6 | A | * information regarding habits (behavioural and dietary) and actions taken ……………………………………... |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |
| 7 | A | * written treatment plan, including, costs given to patient and retained in patient record .……………………………………. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |
| 8 | A | * local anaesthetic and prescription items used are recorded……………………….. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |
| 9 | A | * treatment notes for each visit include date name/identifier of clinician/treatment provided.................... |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |
| 10 | A | * indication for radiographs recorded and radiographs reported…………………….. |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | |
| **\*Checking three records per dentist from the previous six months is recommended (additional records to be checked if standard is not met). Records to be selected by the inspector.** | | | | | | | | | | | | | | | | | | | | | |
| **Information source:** PSM Record-keeping and SDCEP Oral Health Assessment and Review guidance | | | | | | | | | | | | | | | | | | | | |