ULSD Clinic CookBook

From the Class Of 2017

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About

This book is intended as a guide for working in the clinic at ULSD.

Requirements

Operative (D3 only)	Qty.	
Total Prereqs for Competencies (8):		
Four Amalgam Restorations:		
Class I	1	
Class II -1	1	
Class II -2	1	
Class V	1	
Four Composite Resin Restorations:		
Class I	1	
Class II	1	
Class III or IV	1	
Class V	1	
Competencies: D3 Year Only		
Class I (elective)	1	
Class II (required)	1	
Class III/IV (required)	1	
Total Competencies for D3 Year (3)		

Operative (D4 only)	Qty.	
Class II Alloy	1	
Class II Composite	1	
Class III or IV (Composite)	1	
Total Comps for D4 Year (3) *two on mock boards		

OD/OM D3/D4	Qty.	
Clinical Diagnosis Emergency Exams (6) -		
Emergency Patient Comp Exam - 1	1	
Emergency Patient Comp Exam - 2	1	
Emergency Patient Comp Exam - 3	1	
Emergency Patient Comp Exam - 4	1	
Emergency Pt. Comp Exam - 5 **(D4 Only)**	1	
Emergency Pt. Comp Exam - 6 **(D4 Only)**	1	
*no less than 2 completed during the D4 yr		
Oral Med Clinical Experience Portfolio		
Med Consults (at least 1 ASA III or IV)	3	
POMH Summaries (3 - ASA III or IV)	8	
Presentation to Oral Med. Faculty Eval	1	

Pediatrics	Qty.	
Competencies:		
Treatment Plans (2)		
Treatment Plan - 1	1	
Treatment Plan - 2	1	
Class II on Primary Molars (1)	1	
Pulpotomy - (1)	1	
SSC (1)	1	
Sealants (4)		
Sealant - (1)	1	
Sealant - (2)	1	
Sealant - (3)	1	
Sealant - (4)	1	
Space Maintenance (1)	1	
Special Needs (1)	1	
Nitrous Competency (1)	1	
minimum 20 days in Peds. Clinic		

Oral Surgery	Qty.	
Written Competency D3 Year	1	
Written Competency D4 Year	1	

Treatment Planning	Qty.	
D3 Year		
Completed Tx Plans through D3	3	
Competencies (2)		
Ideal Tx Plan Written Competency	1	
D3 Case-Based Examination	1	
D4 Year		
Competencies:(2)		
D4 Case-Based Examination	1	
Tx Plan Case Complete Presentation	1	

Fixed Partial Dentures	Qty.	
Units of Crown and Bridge (12)		
Crown and Bridge D3 Year - 1	1	
Crown and Bridge D3 Year - 2	1	
Crown and Bridge D4 Year - 1	1	
Crown and Bridge D4 Year - 2	1	
Crown and Bridge D4 Year - 3	1	
Crown and Bridge D4 Year - 4	1	
Crown and Bridge D4 Year - 5	1	
Crown and Bridge D4 Year - 6	1	
Crown and Bridge D4 Year - 7	1	
Crown and Bridge D4 Year - 8	1	
Crown and Bridge D4 Year - 9	1	
Crown and Bridge D4 Year - 10	1	

CD & RPD	Qty.	
One CD/CD D3 Year	1	
One CD/CD D4 Year	1	
Two Additional RPDs Plus Comp Exam		
RPD - 1	1	
RPD - 2 **(workup only)**	1	
Competency Exam		
Misc. CD/ RPD Procedures - (5)		
Miscellaneous RPD Procedure - 1	1	
Miscellaneous RPD Procedure - 2	1	
Miscellaneous RPD Procedure - 3	1	
Miscellaneous RPD Procedure - 4	1	
Miscellaneous RPD Procedure - 5	1	

Endodontics	Qty.	
D3 Year		
Simulation Mode/Typodont	1	
Single Canal or Simple Case Experience	1	
Single Canal or Simple Case Experience	1	
Single Canal Endo Comp (Sim/Typodont)	1	
D4 Year		
Endo Experience (Patient)	1	
Endo Experience (Patient)	1	
Molar Endodontic Comp (Simulation)	1	

Periodontics D3/D4	Qty.	
Prerequisites for Competencies		
Preventive Counseling (3)		
Preventive Counseling - 1	1	
Preventive Counseling - 2	1	
Preventive Counseling - 3	1	
Comprehensive Perio Exams (4)		
Comprehensive Perio Exam - 1	1	
Comprehensive Perio Exam - 2	1	
Comprehensive Perio Exam - 3	1	
Comprehensive Perio Exam - 4	1	
Quad SRP (5) - 1-3 Teeth = 1/2 Quad		
Quad SRP - 1	1	
Quad SRP - 2	1	
Quad SRP - 3	1	
Quad SRP - 4	1	
Quad SRP - 5	1	
Periodontal Re-evaluation (1)	1	

Periodontics D3/D4 Continued...	Qty.	
Comps Completed by Graduation		
Preventive Counseling - 1	1	
Preventive Counseling - 2	1	
Preventive Counseling - 3	1	
Preventive Counseling - 4	1	
Preventive Counseling - 5	1	
Comprehensive Perio Exam - 1	1	
Comprehensive Perio Exam - 2	1	
Comprehensive Perio Exam - 3	1	
Comprehensive Perio Exam - 4	1	
Quad SRP - 1	1	
Quad SRP - 2	1	
Quad SRP - 3	1	
Quad SRP - 4	1	
Quad SRP - 5	1	
Periodontal Re-evaluation	1	
Periodontal Re-evaluation	1	
Phase II Completed Perio Case - 1*	1	
Phase II Completed Perio Case - 2*	1	

Orthodontics		
Patient Consults (5)		
Patient Consult (D3 Year) - 1	1	
Patient Consult (D3 Year) - 2	1	
Patient Consult (D3 Year) - 3	1	
Patient Consult (D4 Year) - 1	1	
Patient Consult (D4 Year) - 2	1	
Enter D9310 into Axium for Credit		
Competency Exam: Spring of D4 Year	1	

Exams

Exam Types

Admissions Exam

1- Full Barriers

2- Axium
- a. Chart add screening= D0190
- b. Chart add Pano= D0330
- c. Add admissions/triage form

3- Take Vitals (BP, HR, RR, Temp)- write them on butcher paper

4- Take medical history- check with triage form
- a. Pt must sign
- b. Present to faculty (they determine ASA class- ASA class 1 = normal healthy patient, ASA class 2 = patient with mild systemic disease ASA class 3 = patient with severe systemic disease like crazy BP)
- c. IF Patient needs medical consult
  - i. Add Med/Dent history form
  - ii. Complete first tab
  - iii. Get MD/Doc info
  - iv. Patient must sign
  - v. Add medical consult form
  - vi. Chart Add D0093E

5- Faculty Swipe
6- Take for a Pano- write down patient number before you go, discuss school policy on Pano
7- Hard/Soft Tissue Exam
8- Dismiss Patient (tell them they will hear from us in 2-8 weeks)
9- Do PARTS note:
- a. P= Patient comes in for screening visit CC = “patient quote”
- b. A= MH reviewed, vitals recorded, BP, HR, RR
- c. R= None
- d. T= Screening completed, Radiographs taken, Med consults given
- e. S= Assign to D3/D4/GPR (after med consult)

10- Faculty Approval/Swipe- COMPLETE CODES FIRST

Comprehensive Exam

Prior to Start Check

1. Obtain Exam Kit from dispensary (get bowl and spatula, facebow and regasil from disp too, get impression trays, rope wax from cart and alginate, thermometer from cabinet)
2. Ask patient if they are in pain (if yes, now in emergency apt.)
3. Take MH, DH, have patient sign
4. List Tx modifications if needed
5. Take vitals- BP, HR, RR, temp
6. Make sure general consent form is signed and current (w/I past year)
7. Pull up PANO from screening- keep minimized in bottom of the screen
8. Open exam kit- place bib and glasses on patient
9. Chart add diagnostic procedures
    a. D0150- comp oral exam
    b. D0470- Diagnostic casts (NOT necessary on pts with no restorative needs)
    c. D0210- intraoral complete series
    d. D0080- Perio exam
    e. D0105- Caries risk assessment
    f. Pertinent consult codes

Present to Faculty

1. Place Mirror and Explorer on bracket table
2. Introduce Patient
3. Advise faculty of purpose of apt
4. Have MH displayed on screen and MiPacs minimized at bottom
5. Report vitals, tx modifications and allergies
6. Get faculty swipe on both MH form and proposed TX for the day

DATA Gathering for Comp Exam

1. Obtain FMX- But may only need 4 BWX if pt has good oral health
2. Complete perio exam (request perio faculty approval)

a. If PT has periodontitis that is bad enough to be evident all over the PAN or FMX, may not need to do periodontal charting- complete an explanation in progress note and have it signed by group manager

3. Do hard and soft tissue charting- have approval from group manager afterwards
4. Get Diagnostic Impressions done- DO ON FIRST APPT- get facebow transfer so you can mount
5. Complete CRA form- get faculty approval
6. Appropriate consults added in Axium and scheduled
7. Complete Narrative note about procedures and data from that day's appointment- BE SPECIFIC

Transfer Exam

Prior to Start Check

1. Obtain Exam Kit from dispensary (get bowl and spatula, facebow and regasil from disp too, get impression trays, rope wax from cart and alginate, thermometer from cabinet)
2. Ask patient if they are in pain (if yes, now in emergency appt.)
3. Update MH, have patient sign if change
4. List Tx modifications if needed
5. Take vitals- BP, HR, RR, temp
6. Make sure general consent form is signed and current (w/I past year)
7. Pull up radiographs- keep minimized in bottom of the screen
8. Have diagnostic casts available
9. Chart add diagnostic procedures
    a. D0150-a transfer exam
    b. D0274- 4 BWX (might need FMX instead, might not need if BWX within year, or 6 months if high CRA)
    c. D0470- Diagnostic casts if needed- not needed if no restorative needs
    d. D0080- Perio exam
    e. D0105- Caries Risk Assessment

10. Place patient bib and eyewear on pt.

Present to Faculty

1. Place Mirror and Explorer on bracket table
2. Introduce Patient
3. Advise faculty of purpose of apt
4. Have MH displayed on screen and MiPacs minimized at bottom
5. Report vitals, tx modifications and allergies
6. Get faculty swipe on both MH form and proposed TX for the day

DATA Gathering for Comp Exam

1. Obtain radiographs- BWs once a year or 6 months, PANS every 5-10 years if good health, redone if extensive work done
2. Complete perio exam (request perio faculty approval)
3. Do hard and soft tissue charting- have approval from group manager afterwards
4. Get Diagnostic Impressions done- DO ON FIRST APPT- get facebow transfer so you can mount
5. Complete CRA form- get faculty approval
6. Appropriate consults added in Axium and scheduled
7. Complete Narrative note about procedures and data from that day's appointment- BE SPECIFIC

Emergency Exam

Prior to Start Check

1. Obtain Exam Kit from dispensary
2. Take MH, have patient sign
3. List Tx modifications if needed
4. Take vitals- BP, HR, RR, temp
5. Make sure general consent form is signed and current (w/I past year)
6. Pull up PANO from screening- keep minimized in bottom of the screen
7. Chart add diagnostic procedures
    a. D0140- Limited Oral Eval
    b. D0220- First PA
    c. D0230- Each Additional PA
8. Open exam kit- place bib and glasses on patient

Present to Faculty

1. Place Mirror and Explorer on bracket table
2. Introduce Patient
3. Advise faculty of purpose of apt
4. Have MH displayed on screen and MiPacs minimized at bottom
5. Report vitals, tx modifications and allergies
6. Get faculty swipe on both MH form and proposed TX for the day

Data Gathering

1. Appropriate provocation tests
2. Appropriate radiographs
3. Get approval

Treatment Planning- LIMITED (Chart Add)

1. Limited Treatment Plan based on clinical findings
    a. At end of TP add D0044- return for further treatment plan
2. Have Tx Plan approved by faculty
3. Present Tx Plan to Pt and obtain signature
4. Proceed with appropriate emergency treatment
5. Notify Pt of post op instructions and possible future treatment
6. Write SOAP note
    -SOAP: Subjective, Objective, Assessment, Plan

Coninuing Care Clinic

CDT codes primarily used for CCC Limited Treatment Plan:

Periodic Oral Evaluation	D0120
Full Mouth Radiographs	D0210
4(2) Bitewing Radiographs	D0274(2)
Panoramic Radiograph	D0330
Oral Hygiene Instruction	D1330
Adult Prophylaxis	D1110
Periodontal Maintenance	D4910
Treatment Plan Presentation	D0047

Before Clinic:

1. The day before log into Axium to see if you have a patient assigned.
    A. Prepare limited treatment plan that should include
        i. Periodic Oral Evaluation
        ii. OHI
        iii. Adult Prophy
            (a) If patient has history of SRP Perio Maintenance should be treatment planned D4920
        iii. Radiographs depending on how long it has been since last radiographs using the following intervals:
            (a) Pano: 3 -5 years
            (b) FMX: 2 years
            (c)Bitewings: 1 year
    B. Complete DMD CCC Evaluation form found in Axium. Be sure to write down the following information as you cannot lookup the information while completing the evaluation:
        i. Patient Name
        ii. Patient Chart #
        iii. History of Medical Consult if any and date with date of labs if any
        iv. Date of last complete series if any
        v. Date of last pano if any
        vi. Date of last bitewings if any
        vii. Date of last follow up PAs if any
        viii. Date odontogram was last updated
        ix. Date of SRP if any
        x. Preliminary diagnosis
        xi. Date of limited treatment plan

Supplies:

A. Window
    1. Prophy kit
    2. Cavitron tip
B. Cart
    1. Cavitron
    2. Floss
    3. Prophy paste (fine for crowns/implants, medium for regular teeth not for SRP)
    4. Prophy cup angle
    5. Tooth brush and tooth paste if you are doing OHI
    6. Disclosing agent (also for OHI)
    7. Extra gauze if you are doing an SRP, it will be bloody
    8. A red hazardous waste bag to put all your bloody gauze in

Prior to Startcheck:

1. Full barriers setup by 8:30 am.
2. Get prophy kit from window
3. Get treatment plan approved by faculty
4. Get MH, DH, and patient signature
5. List treatment modifications if needed
6. Take vitals, BP, HR, RR, temp
7. Make sure general consent form is current and signed within the last year.
8. Get patient to sign and approve treatment plan.
    A. Explain the charges and procedures for the day
9. Open exam kit, place bib and glasses on patient

Present to Faculty

1. Place Mirror and Explorer on bracket table
2. Introduce Patient
3. Advise faculty of purpose of apt
4. Have MH displayed on screen and MiPacs minimized at bottom
5. Report vitals, tx modifications and allergies
6. Get faculty swipe on both MH form and proposed TX for the day

Procedures:

1. Do hard and soft tissue charting and take notes of any changes since last appointment
2. Do prophy or perio maintenance
3. Change procedures from in process to completed
4. Place Mirror and Explorer on bracket table and get faculty approval
5. Release patient

After Appointment

1. Write narrative note
2. If any restorative treatment needs to be done fill out blue card and fill out the Axium Continuing Care Clinical Referral Form

Med Consult

Form:

- DMD oral medicine consult (D0093E)

Links:

- Lexi-comp: medications
- ULSD Oral Medicine Clinical Patient Mgt Guidelines: consult info (pg 3)

Consult:

- 1st paragraph: Opening Statement
- always the same
- cut and paste from pg 3
- 2nd paragraph: Health History
- (Patient's) current medical problems and pertinent past medical history includes: bullet points
- 3rd paragraph: Midcation List
- (Patient's) current medications are reported as: bullet points
- include all
- 4th paragraph: Question
- cut and paste from axium oral medicine guidelines
- Closing Statement
- "Thank you for your assistance in my care of our mutual patient."
- Request form from Abigayle Hislop

Reply:

- Consult template note to summarize doctor reply
- Department:
- Findings and Results:
- Patient is suitable for comprehensive care with the following treatment modifications:

Consult Needed:

- Allergy:
- Local anesthetic (sulfites)
- Dental materials (mercury, nickel, methylmethacrylate, etc)
- Unresolved Infectious Disease
- TB, pulmonary MRSA
- Medical Problems:
- Angina pectoris
- History of myocardial infarction
- History of cerebrovascular accident / transient ischemia attack
- Cardiac insufficiency / congestive heart failure
- Hypertension (defined as BP > 140 mm Hg systolic and/or 90 mm Hg diastolic)
- Cardiac arrhythmia
- Diabetes mellitus
- Chronic obstructive pulmonary disease
- Poorly controlled and/or exercise-induced and/or stress-induced asthma
- Symptomatic hypo- or hyperthyroidism
- Poorly controlled seizure disorder (defined as > 1 seizure per month)
- Hepatitis, hepatic failure, or cirrhosis
- Chronic kidney disease, renal failure and/or dialysis
- Adrenal insufficiency
- Post Treatment Infection Risk:
- HIV/AIDS
- Blood dyscrasias, aplastic anemia
- Myeloproliferative disease (e.g., leukemia, myelofibrosis), lymphoma
- Use of systemic corticosteroids and/or other immunosuppressive drug use (e.g., tumor necrosis
- factor blockers [e.g., etanercept, infliximab, adalimumab, etc.], azathioprine, methotrexate)
- Undergoing antineoplastic cytotoxic chemotherapy
- History of radiation therapy involving the maxillofacial region
- Status-post organ, bone marrow or stem cell transplant
- Homeostasis Medications/Problems:
- Hemophilia, von Willebrand's disease
- Thrombocytopenia, thrombocytopathia
- Warfarin (Coumadin)
- Direct thrombin inhibitors (e.g., Pradaxa)
- Factor Xa inhibitors (e.g., Xarelto, Eliquis)
- Low-molecular-weight heparin (LMWH) such as enoxaparin (Lovenox)
- Valproic acid (valproate sodium)
- Psychiatric or Cognitive Problem

Procedures

Nerve Blocks

Mandibular

Nerve Block	Gauge & Needle Length	LA Delivered (cc)	Target	Intra-Oral Technique for Pentration	Needle Length Inserted	Bevel Oriented	Nerve Anesthetized
MANDIBULAR BLOCK *Techniques (4)*							
I. Conventional	25 Long	1.6 cc 0.2 cc -LB	Large area Lies along a line that is defined by deepest extent of the mesial concavity of the ascending ramus Extension is parallel to the occlusal plane of the mandibular teeth	Align the barrel w/ contralateral premolars & parallel to the occlusal plane *Barrel should be off the mandibular teeth Penetrate the "dimple" If bone is contacted before depth is reached (because lingual), reposition needle so barrel is more toward midline	2/3-3/4 □ Bone is contacted (17-19mm)	Toward Ramus	Target only Lingual & IAN
II. Uni-linear	25 Long	1.8 cc (2-part delivery)	1 cm superior to Conventional technique Area where the IAN, Lingual and Long Buccal nn are closest together	Penetration of mucosa 1cm above the dimple of the Posterior Triangle □ insert to 1/2 (fem)-2/3(male) needle length Swing barrel to opposite C/P area & advance until bone contact Withdraw 2mm & deposit ¾ carpule Slowly withdraw/ deposit remaining LA	Bone is contacted		Target all 3 nn. IAN, Long Buccal Lingual
III. Vazirani-Akinosi	25 Long	1.8 cc	Medial Border of the Ramus *Mouth is closed *After injection, sit pt upright	Penetrate at the mucogingival junction of the maxillary 2nd molar & advance a slightly lateral direction Insert until the needle hub is at the interdental papilla of the 1st & 2nd molars (or last two molars present)	Bone is *not* contacted	Toward Maxillary Teeth	
IV. Gow-Gates	25 Long	1.8 cc	*Superior than all others* *Anteriomedial side of condylar neck* **After injection, must sit pt upright for 5 min w/ mouth open for 1-2min*	Penetration just distal to the Max 2nd molar at the height of the cusp tip of the ML Cusp Barrel aligned w/ imaginary line from intertragus notch & opposite corner of the mouth	¾ needle length □ Bone is contacted	Not Critical	
ACCESSORY							
Long Buccal Nerve Block	25 Long	0.2 cc	Anterior border of the Ramus	Penetration is made distal & buccal to the most distal molar tooth Needle parallel to occlusal plane but buccal to the teeth If shallow tissue, reposition needle □ 45° angle/ laterally	Just the Bevel (1-4 mm)	Toward bone	Targets only the Long buccal n (Buccal gingival for the molars)

0.9-1.0 cc = ½ the Carpule 0.25 cc = 1/4th the Carpule 1.2cc = 3/4th the carpule Always pull the lip TIGHT

Gauge & Needle Length	LA Delivered (cc)	Target	Intra-Oral Technique for Pentration	Needle Length Inserted	Bevel Oriented	Tissues Anesthetized	
Mental Nerve Block	25 Long or 27 Short	1.0 cc	Mental Foramen Usually between apices of the premolar *Feel for the neurovascular bundle & avoid it	Penetration is made in the depth of the vestibule Just anterior or posterior to the neurovascular bundle Apply Pressure on the area that has "ballooned after injection to force LA into the Mental foramen	Just the Bevel	Toward Bone	All tissue inn. . by the Mental n.
Mylohyoid Nerve Block	25 Long or 27 Short	1.0 cc	Lingual Just medial to the 2nd Molar	Penetration is made at the depth of the lingual vestibule at a 45° angle to the long axis of the molar	1/4-1/3	Toward Bone	Mandibular Insicor & molar in some individuals *Indicated with the lower incisors are still sensitive about a good mandibular block
C3 Nerve Block	25 Long	0.9-1.0 cc	Buccal Vestibule Lateral to the 2nd molar or 3rd if present	Penetration is made at the depth of the buccal vestibule Needle position toward the angle of the mandible	01/02/15	Toward Bone	Runs along the inferior border of the mandible & sends sensory branches to the mand. Molars *Indicated when mandibular molars are still sensitive about a good mandibular block

0.9-1.0 cc = ½ the Carpule 0.25 cc = 1/4th the Carpule 1.2cc = 3/4th the carpule Always pull the lip TIGHT

Maxillary

Nerve Block	Gauge & Needle Length	LA Delivered (cc)	Target	Intra-Oral Penetration Site	Needle Length Inserted	Bevel Oriented	Innervation Teeth Tissue	
ASA: Anterior Superior Alveolar Nerve	27 Short	0.9-1.0 cc	Apical & slightly distal to the canine *Look for Canine eminence	Along the long axis of the canine root At the height of Mucogingival fold To apical region of the tooth	1/3-1/2	Toward Bone	Canine Ipsilateral Incisors	Labial mucosa & inner aspect of the Lip to mid-line
MSA: Middle Superior Alveolar Nerve	27 Short	0.9-1.0 cc	Slightly Apical to Either the 1st or 2nd Premolar *Look at Frenula to direct the needle insertion	Along the long axis of the Premolar chosen as target Same insertion as ASA	1/3rd	Toward Bone	1st Premolar 2nd Premolar 1st Molar (medially)	Buccal Gingiva in Premolar/1st Molar region
PSA: Posterior Superior Alveolar Nerve	27 Short	0.9-1.0 cc	Apical to the Root of the 3rd molar *AVOID the Pterygoid plexus	Just lateral to the 2nd Molar At a 45° angle to the long axis of the tooth At an angle approaching 45° medially *Anatomy Dictates Medial	01/02/15	Toward Bone	3rd Molar 2nd Molar 1st Molar (distally)	Buccal Ginigiva in Molar regions
GP: Greater Palatine Nerve	27 Short	0.25 cc *Until tissue blanches (size of a Dime)*	Greater Palatine Foramen *Visualize & Palpate before injection *Apply pressure over foramen w/cotton tip applicator to during initial injection	Just anterior to the Greater palatine foramen ½ inch medial to the disto-palatal cusp of 2nd molar Needle positioned nearly perpendicular to mucosa	Just the Bevel	*Away from Bone*	None	Palatal Soft tissue: Distal of Canine to jxn of Hard/Soft palate & to midline Palatal Bone in same region
NP: Nasopalatine Nerve	27 Short	0.25 cc *Until tissue blanches (width of both Centrals)*	Incisive Foramen *Apply pressure immediately behind the central that you aren't injecting beside during the initial injection. Apply force towards the nose!	Just lateral to the incisive papilla Toward the posterior portion of the papilla At a 45° angle to the palatal bone	Just the Bevel	Toward Bone	None	Palatal soft tissue: Anterior portion of hard palate from distal of canine to other canine Palatal Bone in same region
IO: Infra-Orbital Nerve	25 long or 27 Short	0.9-1.2 cc	Near the Infra-orbital Foramen Inferior to the Orbital rim	Parallel to 1st premolar long axis Angle toward the Infra-orbital foramen	01/02/15	Toward Bone	Canine Ipsilateral Incisors (75%: Premolars + 1st molar)	Buccal gingival of Associated teeth, Skin of the lower eye, lip, & nose
Local Infiltration: Supraperiosteal Injection ONLY for the Max.	27 Short	0.6 cc True amount depends on Tx	Apical region of area to be anesthetized	Along the long axis of the Maxillary target tooth To the apex	To Apical Target	Toward Bone	Pulpal Anesthesia of 1-2 teeth	Soft tissue of limited area

0.9-1.0 cc = ½ the Carpule 0.25 cc = 1/4th the Carpule 1.2cc = 3/4th the carpule Always pull the lip TIGHT

Anesthetic Math Quicksheet

MEPIVACAINE	3	400 mg	2% 3%	36mg 54 mg	11.1 7.4
PRILOCAINE	3.6	600 mg	4.00%	72 mg	8.3
ARTICAINE	3.2	None	4.00%	72 mg	None
BUPIVACAINE	None	90 mg	0.50%	9 mg	10

	Healthy Patient		**Cardiac Patient**	
	Max dose/ appointment	**Number of Carpule**	**Max dose/ appointment**	**Number of Carpule**
1:50,000 Epi (0.036 mg)	0.2 mg	5.5	0.04 mg	1.1
1:100,000 Epi (0.018 mg)	0.2 mg	11.1	0.04 mg	2.2
1:200,000 Epi (0.009 mg)	0.2 mg	22.2	0.04 mg	4.4
1:20,000 Levonordefrin (0.09 mg)	1.0 mg	11.1	0.2 mg	2.2

Calculations:

MRD for a patient = Patient's weight X Max dose/lb.

*Remember to compare to ARD for each drug

Operative

Restorations

Composite

A. Window
1. Operative kit (comes with bur block, hand pieces, and rubber dam kit)
2. Composite shade guide
3. Composite kit (comes with composite gun, etch and bond)
4. Composite set up (it's a cup with all the polishing tips you need, a matrix band and occlusion paper)
5. Possibly a garrison ring system
6. The titanium kit
7. You might want to get a friction grip for your slow speed (doesn't come in the operative kit)
8. Curing light (if you don't have one in your cubicle)

B. Cart
1. Purple operative sheet!
2. Punch two rubber dams just to start with just in case you rip one
3. Extra matrix bands
4. Scalpel blade (if that's what you like to use)
5. Finishing strips
6. Dycal (if you end up needing it)
7. Wedges
8. Hemodent (Keeps it from getting too bloody if you are subgingival)
9. Hibiclens- Antibacterial agent

Amalgam

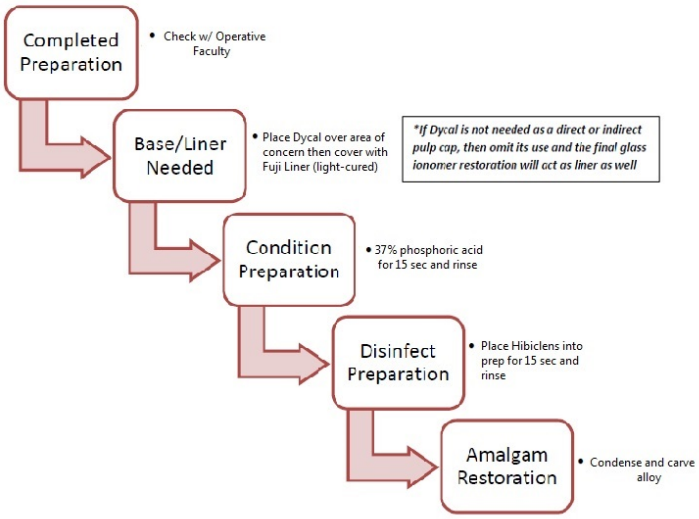
A. Window (just ask for amalgam set up- amalgam, matrix band, occlusion paper)
1. Operative kit (comes with bur block, hand pieces, and rubber dam kit)
2. You might want to get a friction grip for your slow speed (doesn't come in the operative kit)

B. Cart
1. Purple operative sheet!
2. Punch two rubber dams just to start with just in case you rip one
3. Extra matrix bands
4. Scalpel blade (if that's what you like to use)
5. Finishing strips
6. Dycal (if you end up needing it)
7. Wedges
8. Hemodent (Keeps it from getting too bloody if you are subgingival)
9. Hibiclens- Antibacterial agent
10. Order- Dycal (If needed)- Hemodent (If needed)- Hibiclens-Amalgam

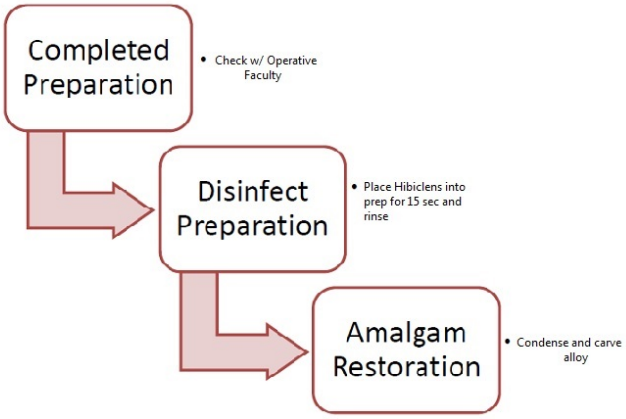
Flow Charts

Amalgam

Deep Prep

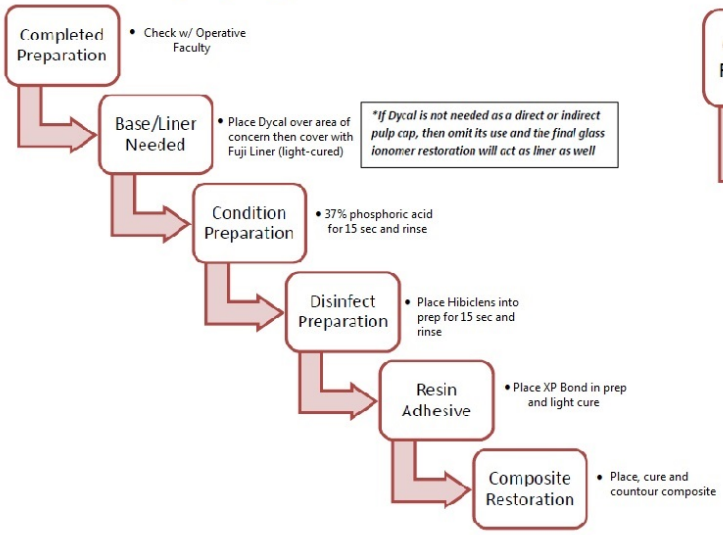


Normal Prep

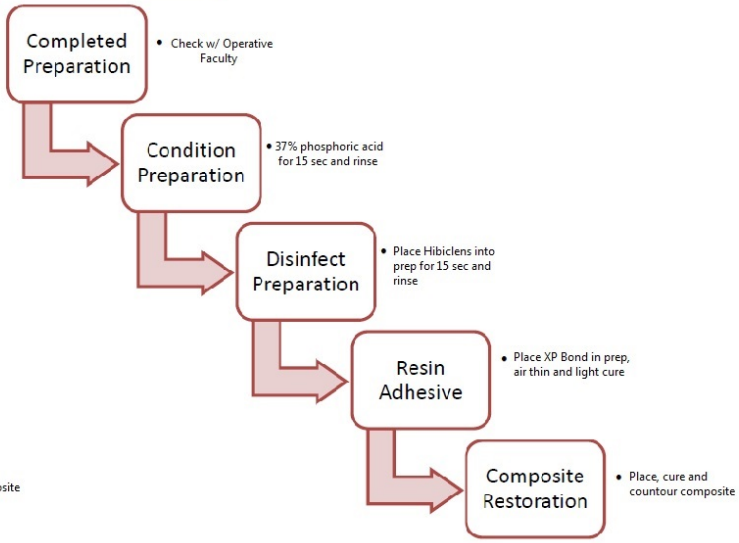


Composite

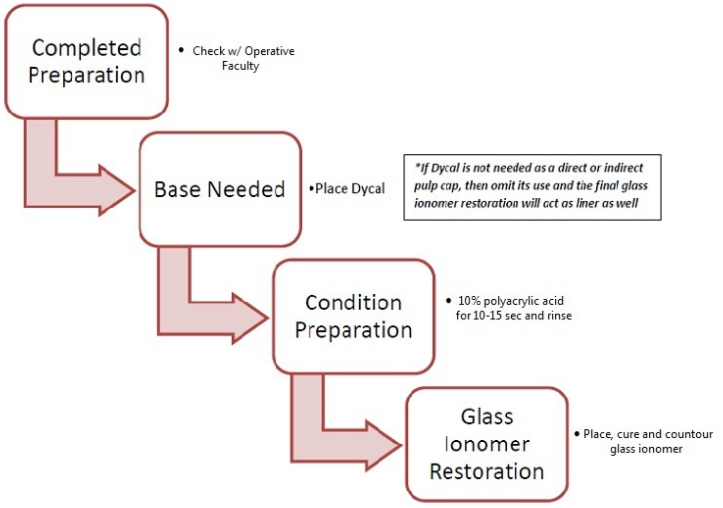
Deep Prep



Normal Prep



Glass Ionomer



Bases:

· Dycal (CaOH): Calcium Hydroxide is used for direct and indirect pulp capping in those deep caries cases or over-prepared teeth where secondary dentin formation is needed to maintain vitality of the pulpal tissue

- It is both highly soluble and brittle (poor compressive strength)
- It must be covered with a resin-modified glass ionomer (Fuji Lining) liner as comprehensive therapy

Liners and Sealers:

· Fuji Lining (Resin-Modified Glass Ionomer): Used for covering bases (Dycal) and occluding dentinal tubules to prevent post-operative sensitivity in those moderate caries cases or where over-prepared teeth have occurred.

- Low solubility and less brittle than bases (Dycal)
- Light Cure Material
- Only place over base or on the pulpal/gingival floors (NOT ON WALLS)

· XP Bond (Light-Cured Bonding Agent): Used in those routine cases to occlude dentinal tubules and seal enamel cavosurface margins in ideal preparations.

- Used under amalgam (liner) and composite (adhesive) direct restorative materials
- Light Cure Material
- Can be used over resin-modified glass ionomer liner following proper cure

Materials

1. Anesthetics :

(a) Topical – Lolli-Caine
(b) Lidocaine 1: 100,000
(c) Septocaine 1:100,000 (also known as Articaine)

2. Medicaments:

(a) Dycal – contains calcium hydroxide. It is an irritant which causes secondary dentin to be laid down.
(b) Eugenol- This is for inflamed pulp tissues. It is contained in IRM. We use this as a sedative restorative material. It is a temporary material.

3. Liners and Bases:

(a) A liner and a base must have great compressive strength. In reality, the only difference in the two is the way in which it is applied. A liner is relatively thin while a base is much thicker.
(b) Mostly you will use a glass ionomer liner (Vitrebond) because of its' compressive strength and the fact that it contains fluoride.

4. Bonding Agent:

(a)We use Optibond here at ULSD. When you are restoring a tooth it is imperative that you clean the prep with Hibiclins and rinse after etching and prior to placing your bonding agent. Prior to air thinning your bonding agent, blow the air on your gloved hand to make sure that no moisture is contaminating the bonding agent.

5. Restorative Materials:

(a) Alloy: We use Permit. Alloy stands up to the high compressive strains placed on second molars better than composites.
(b)Composite – We use Ivoclar Tetric as our composite. Remember moisture is not your friend. Composites are much more technique sensitive than alloys. You must control your field.
(c) Glass Ionomer Fill – We use Fuji II Again this a bonded restoration and while it tolerates moisture, I prefer to control my field as well as possible. It has the advantage of tolerating some moisture as well as containing fluoride. It will use the same code as composite resin in axiom.
(d) Fuji IX is a glass ionomer material which we use as a temporary fill or even a base material. It is even uglier than Fuji II. But it is a useful material.

6. Temporary Filling Materials :

(a) IRM this contains eugenol and is the material to use when we have a pulpitis. We remove decay and place the IRM and let the tooth set for a few weeks to see if the pulp will calm down.

7. Core Paste Material:

(a) Paracore is the material we use at ULSD. This is a wonderful material that I used often in my practice. When doing a large buildup for a tooth we are going to crown, we

8. Cements:

(a) the two we use are Rely X Luting Plus and Rely X Unicem 2. You can talk with a faculty member.

9. Hemostasis:

(a) If you need to do a restoration that is close to tissue and there is bleeding, the material of choice is Viscostat. You get this at the dispensary window along with a mop tip. You extrude the material through the mop tip directly onto the tissue. You gently massage or burnish the viscostat on the tissue where it is bleeding for 45 seconds. Then you rinse the tissue thoroughly. You will probably have a dry field at that point. In not, repeat the procedure. It should be fine. Some people may recommend Hemodent for a hemostatic agent.

Perio

Supplies

What you need:

A. Window
   1. Prophy kit
   2. Cavitron tip

B. Cart
   1. Cavitron
   2. Floss
   3. Prophy paste (fine for crowns, medium for regular teeth not for SRP)
   4. Prophy cup angle
   5. Tooth brush and tooth paste if you are doing OHI
   6. Disclosing agent (also for OHI)
   7. Extra gauze if you are doing an SRP, it will be bloody
   8. A red hazardous waste bag to put all your bloody gauze in

Perio Exam

1. ONLY use the D0080 code
2. Must be updated annually
3. Charge out procedure for credit
4. Use the liquid stain for PI
5. 3 items in the separate consult note
6. Competencies only on active Perio Disease patients
7. PF
8. Probing is considered INVASIVE!!

OHI

1. Oral Hygiene Instructions (AF)D1330
2. Stain teeth with liquid stain
3. Mark the areas in aXium for the index
4. Have covering faculty check
5. Review OH and have patient remove all evidence of plaque
6. Pt should have a take home bag of items necessary for OH and written instructions
7. ALL competencies MUST have an approved PI entered in aXium

Prophylaxis

1. Dental Prophylaxis D1110
2. Usually on Gingivitis cases
3. Recall every 6 months
4. Remove all evidence of plaque, calculus and staining
5. Review OHI
6. DO NOT polish calculus!
7. AF

SRP

1. Scaling and Root Planing D4341 and/or D4342
2. MUST have pocket depths equal or greater than 4mm
3. MUST be anesthetized NO EXCEPTIONS!
4. ONLY begin ONE quadrant at a time
5. DO NOT Cross the midline without instructor permission
6. Give detailed post-op instructions POIG in chart
7. Do NOT charge an additional prophy
8. Polish ONLY at Reval appointment
9. Enter teeth on 1-3 teeth in aXium when tx planning
10. PF

Perio Reevaluation

1. Periodontal RevalD0084
2. Mark PI
3. Mark probing depths for all remaining teeth
4. Run analysis in aXium for comparison
5. Determine if patient is to be on:
6. Periodontal Maintenance
7. Referral to Graduate Periodontics
8. 4-6 weeks after last SRP
9. New Diagnosis only if Dx is more severe
10. PF

Perio Maintenance

1. Periodontal Maintenance D4910
2. Review OH
3. Check probing depths of concern
4. If changed you must enter all PD on all teeth
5. Usually 3-4 months
6. Remove all plaque, calculus, stain
7. Reinforce OH procedures
8. (insurance fraud)

Phase I Reviews

1. Phase 1 ReviewsD0040C
2. All phase one procedures tx planned completed
3. Periodontal charting is up to date
4. Recall/Maintenance is up to date
5. INFORM covering faculty of plans for phase
6. 2 treatment especially abutments, teeth for crowns
7. PF

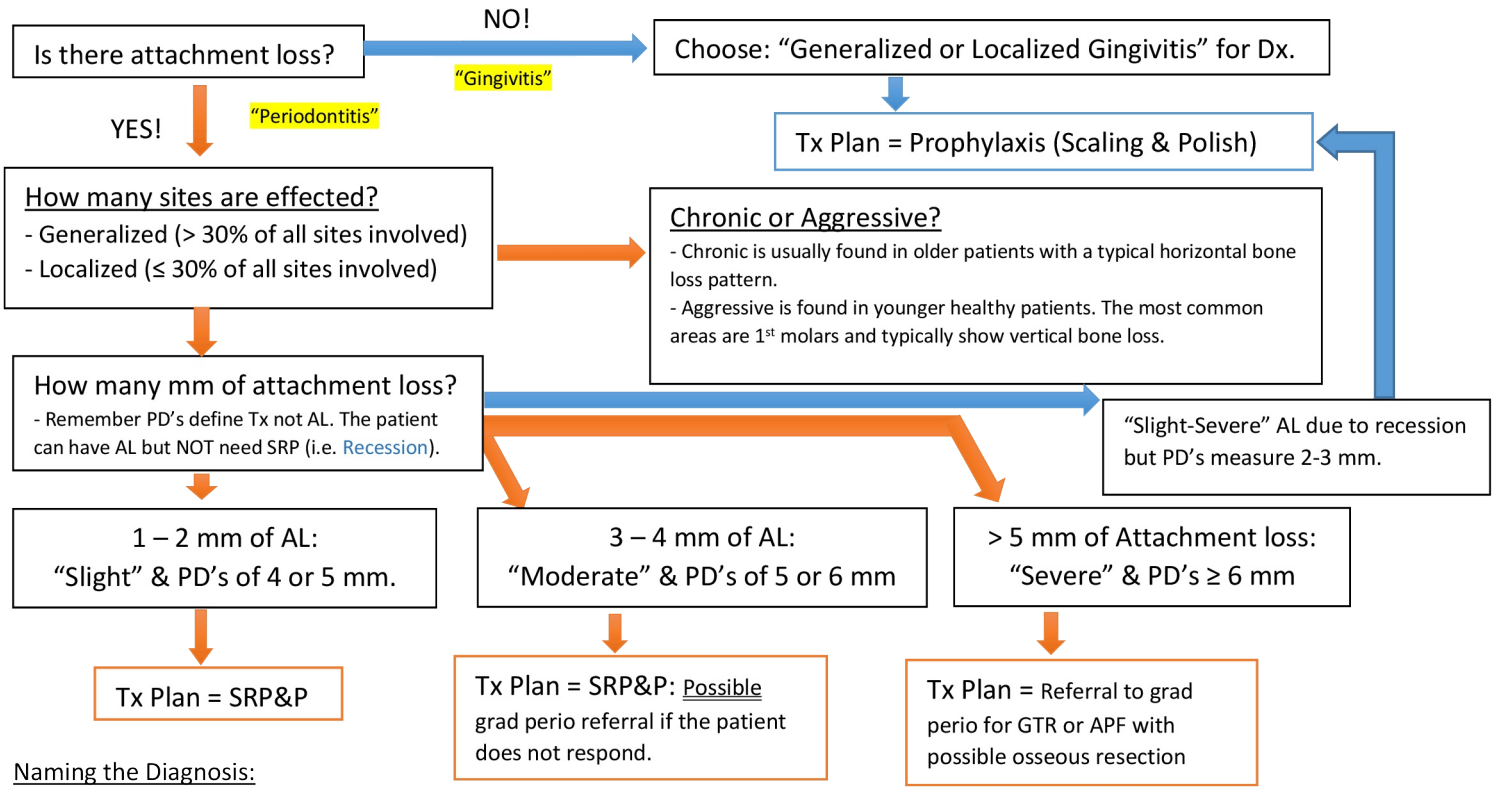
Phase II Reviews

Phase 2 Reviews
All periodontal charting and
recall/maintenance is up to date
Reinforce OH
Pt. is placed on appropriate return procedures
PF

Perio Diagnosis

How to make a Periodontal Diagnosis: ➔ **All Dx is based on the patients *ATTACHEMENT LOSS (AL)!***

1. Look @ radiographs for any interproximal bone loss or questionable areas and mark them down first.
2. Probe all the existing teeth and mark any noticeable recession during the exam.
3. Zero out any PD numbers that are less than or equal to 3 mm.
4. Any PD numbers that are 4 mm need to be compared with the BOP readings.
    a. If BOP occurred in the site then put -2 mm for the GM & have 2 mm of Attachment Loss.
    b. If there was no BOP in the site of a 4mm then based on the conditions of the pts mouth make a call to put -4 of -2 mm. (Usually if the pt has a clean mouth the 4 mm can be normal or will respond to prophy)
        i. *Also look at the signs of HEALTH*: Color / Contour / Consistency / Texture of tissues.
5. Any numbers that are 5 and greater decide to put -2 or -3 mm for GM and that will indicate some Attachment loss.
6. Make a Dx for the patient:



Naming the Diagnosis:

1. Start with Localized or Generalized
2. Name the severity (Slight / Moderate / Severe)
3. Name Chronic or Aggressive
4. Name the disease.

Example Diagnosis:

- Localized Slight Chronic Periodontitis - OR - Localized moderate chronic periodontitis with recession.
- Generalized Severe Aggressive Periodontitis

Remember the Dx can be combined:

- Generalized slight chronic periodontitis with localized severe periodontitis.

Remember: if the only sites of attachment loss are due to recession and the pocket depth in those areas of recession are 2-3 mm the patient can be maintained on routine Prophylaxis and Periodic 6 month recall.

This is a good case where Pocket Depths define Treatment & Attachment loss defines diagnosis.

What to include in a Perio Note:

- Medical/Dental Hx;
- Vitals:
- Medications:
- Allergies:
- Oral Hygiene Instructions:
- Diagnosis:
- Prognosis: (Good / Fair / Poor / Questionable / Hopeless)
- Treatment plan: (Always put OHI first!!!)

1. ***Good:*** *Adequate periodontal support and easy to maintain.*
2. ***Fair:*** *Attachment loss in which good is not predictor, Class I furca.*
3. ***Poor:*** *Moderate attachment loss with class I/II furca.*
4. ***Questionable:*** *Severe attachment loss, poor crown/root ratio, severe class II/III furca, significant root proximity.*
5. ***Hopeless:*** *Inadequate attachment for health, comfort and function.*

• ***Single rooted teeth with initially assigned good prognosis responded best to treatment.***

Fixed Prosthodontics

Crown and Bridge

A. Make sure you get a step card!!!- it's the blue one. You will need a signature from the cashier before you can prep their tooth because they want to make sure they are in good financial standing. You will need a second signature before you take the impression- they have to pay half down (Tell your patients this!!). You will need a third signature from the cashier to cement the crowns (if they aren't on a payment plan they have to have paid it off). If you just need a signature from a faculty, just rip off a piece of paper and write down what you need and have them sign it. Signatures from the cashier go on your step card. You have to take your step card to the window and have them look at it before they give you whatever you need.

B. For survey crowns for an RPD make sure you have a final RPD design approved and have the cast surveyed. Once you have the crowns prepped and your cast poured up in stone before you send it to the lab you have to survey that cast or it won't go through QA. Also you have to survey the crowns when they come back from the lab to make sure they did what you wanted.

C. Window
1. Crown and bridge kit (comes with burs and hand pieces)
2. Crown removal bur Signature from faculty! (If you are removing an old crown)
3. Crown key (you don't need a signature for this - but also if you are taking off an old crown)
4. PVS impression material Signature from faculty and signature (cashier) on the step card.
5. Jet acrylic or Integrity for your temporary (you need a signature from the faculty for integrity- it's worth it and they usually don't care)
6. Regasil to take a bite registration

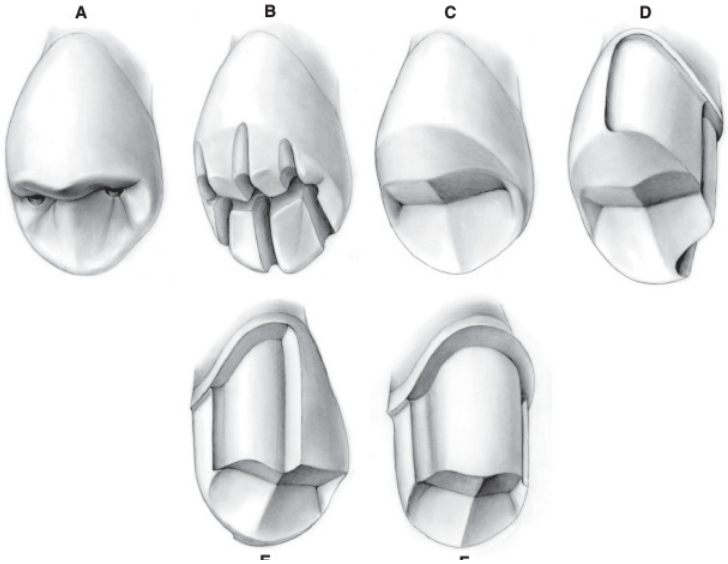
D. Cart
1. Occlusion paper
2. Floss
3. Free-genol temporary cement (there are two tubes- orange and a brown one)
4. I usually grab the sand paper disks and the pogos to shape my temporary with
5. Cord - there is 0 and 00 on the cart (grab both you never know what faculty will tell you. A good trick is to cut off a piece or two and soak it in hemodent, which is also on the cart. That will help control bleeding)

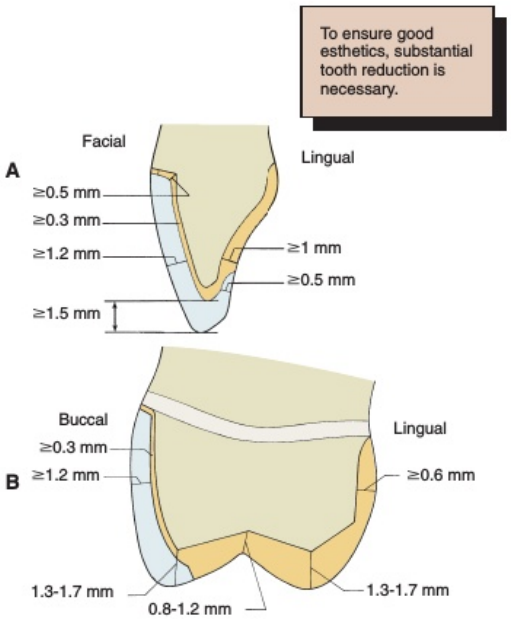
E. Stuff you need to have ready (these steps are on the step card)
1. A custom tray- possibly
2. A suck-down matrix on the tooth you will be prepping to make a temporary.
Crown and bridge (cementation of crown)

F. Window
. Crown and bridge kit
2. Rely-x permanent cement (Will need signature from faculty and on step card from cashier)
3. Porcelain polishing kit

G. Cart
1. Occlusion paper
2. Floss

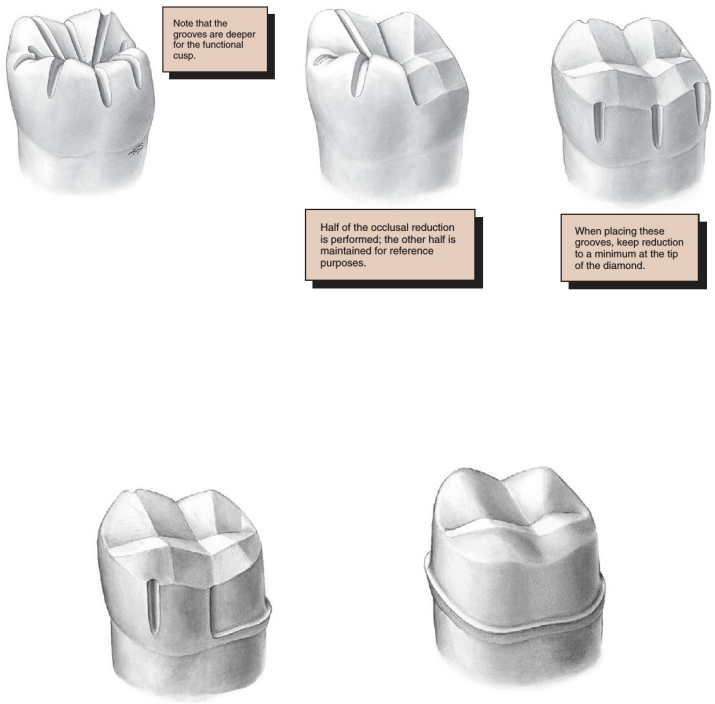
PFM Crown

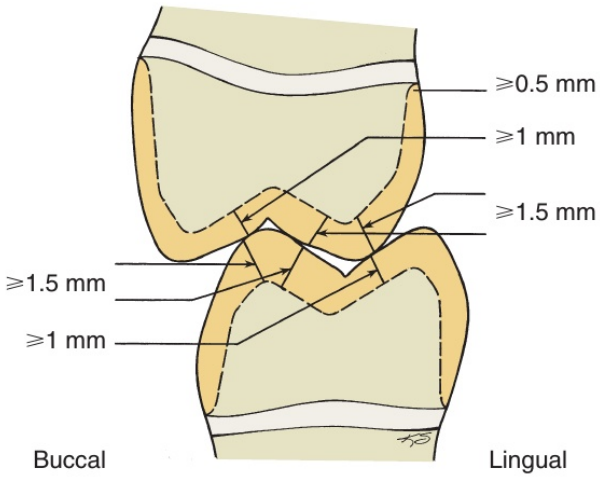




Preparation steps	Recommended armamentarium	Criteria
Incisal (occlusal) reduction guide grooves	Tapered, round-tipped diamond	1.5 to 2 mm of clearance in intercuspal positions and all excursions
Incisal (occlusal) reduction	Tapered, round-tipped diamond	1.2 to 1.5 mm of reduction for metal and porcelain (see Fig. 9-1)
Labial reduction guide grooves (two plane)	Tapered, round-tipped diamond	6 degrees of convergence, as measured as the angle between opposing axial walls
Labial reduction (two plane)	Tapered, flat-tipped diamond	Should provide 1 mm of clearance in all excursions and intercuspal positions (≥1.5 mm if occlusal is porcelain)
Axial reduction	Tapered, round-tipped diamond	Shoulder must extend at least 1 mm lingual to proximal contact area; bevel, if selected, should be as far incisal as possible in relation to epithelial attachment
Lingual reduction	Football-shaped diamond	All line angles rounded and preparation surfaces smooth
Finishing of shoulder (or beveled shoulder)	Tapered, flat-tipped diamond	–
Finishing	Hand instrument Tapered, round-tipped diamond or carbide	–
Incisal (occlusal) reduction guide grooves	Tapered, round-tipped diamond	1.5 to 2 mm of clearance in intercuspal positions and all excursions

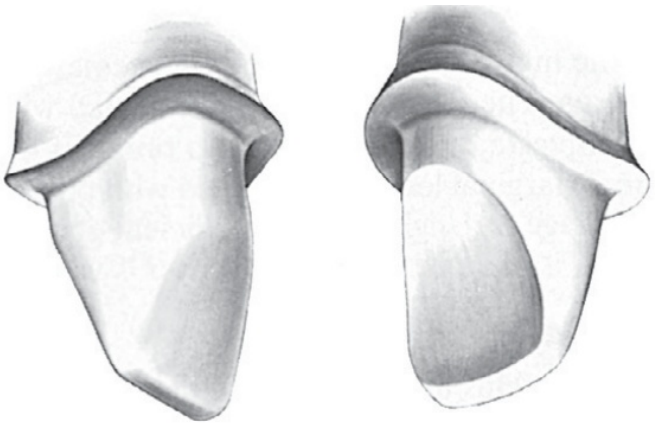
Full Metal Crown



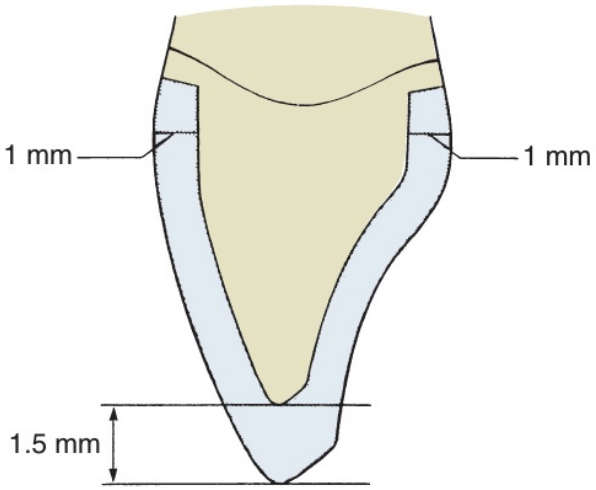


Preparation steps	Recommended armamentarium	Criteria
Depth grooves for occlusal reduction	Tapered carbide or diamond	Minimum clearance on noncentric cusps: 1 mm
Functional cusp bevel	Tapered carbide or diamond	Minimum clearance on centric cusps: 1.5 mm
Occlusal reduction (half at a time)	Regular-grit, round-tipped diamond	Flatter than cuspal plane, to allow additional reduction at functional cusp
Alignment grooves for axial reduction	Tapered diamond	Should follow normal anatomic configuration of occlusal surface
Axial reduction (half at a time)	Tapered diamond	Chamfer allows 0.5 mm of thickness of wax at margins
Finishing of chamfer	Tapered diamond	Reduction performed parallel to long axis
Additional retentive features if needed	Wide, round-tipped diamond or carbide	Smooth mesiodistally and buccolingually; resistance to vertical displacement by tip of explorer or periodontal probe
Finishing	Tapered carbide	Grooves, boxes, pinholes as described for partial-coverage restorations
	Fine-grit diamond or carbide	Rounding of all sharp line angles to to facilitate impression making, die pouring, waxing, and casting

All Ceramic Crown



Note the rounded internal line angles.



Preparation steps	Recommended armamentarium	Criteria
Depth grooves for incisal reduction	Tapered diamond	Approximately 1.3 mm deep to allow for additional reduction during finishing; perpendicular to long axis of opposing tooth
Incisal reduction	Tapered diamond	Clearance of 1.5 mm; check excursions
Depth grooves for facial reduction	Tapered diamond	Depth of 0.8 mm needed for additional reduction during finishing
Facial reduction	Tapered diamond	Reduction of 1.2 mm needed; two planes, as for metal-ceramic crown preparation
Depth grooves and lingual reduction	Tapered and football-shaped diamonds	Initial depth, 0.8 mm; recreate concave configuration; do not maintain any convex configurations (stress)
Depth grooves for cingulum reduction	Tapered diamond	Parallel to cervical aspect of facial preparation; 1 mm of reduction; shoulder follows free gingival margin
Lingual shoulder preparation	Square-tipped diamond	Rounded shoulder 1 mm wide; minimize "peaks and valleys"; 90-degree cavosurface angle
Finishing	Fine-grit diamond or carbide	All surfaces smooth and continuous; no unsupported enamel; 90-degree cavosurface angle

Removable Partial Dentures

Appointments

Codes:

D0150 Comprehensive exam (includes bite registration, radiographs, dx impressions and casts)
D0093-M RPD CONSULT
D5213 Maxillary cast metal framework with resin denture
D5214 Mandibular cast metal cast framework with resin denture
ADD letter for the following:
i. A Master Impression
ii. B RPD Framework try-in
iii. C RPD Wax try-in

A. First appointment: as a part of Comprehensive exam

Supplies:
Cup with mouthwash (Instruct patient to use before impression)
Patient Napkins (2)
Patient safety glasses
Saliva Ejector
Spatula
Mixing Bowl
35 cc Syringe
Alginate (measuring device and scoop)
Disposable tray with adhesive
Rope wax
Cheek retractors
2x2 gauze to clean face
Disinfectant for impression
Labeled bag with wet paper towel for transport to wet lab for pour up
Cast base formers
Window:
Vacuspat Mixing Bowl
Facebow with Nasion and Bitefork
Regisil (bite registration material)

1. Primary Impression!
-Pour Up Diagnostic Casts (ASAP after impression)

*Remember all casts in wet labs are thrown away every Saturday

2. Jaw Registration with Facebow
3. Informal RPD Consult with faculty: discuss TX possibilities with patient

B. Between first and second appt.

1. Construct Baseplates and Occlusion Rims

*Follow instructions in RPD class manual

2. Use Facebow bite record to mount maxillary diagnostic cast on WhipMix Articulator

C. Second appt.

Supplies:
Patient safety glasses
Buffalo Knife
Bunsen Burner/ Hanau Torch
Vaseline
At Window-
Hot water bath
RPD kit (wax spatulas)

1. Preparing Occlusion Rims for Bite Record
a.) Reduce Occlusion Rims until you see a slight amount of space (2-3mm) between rims and natural teeth and teeth are in occlusion without occlusion rim interference (This makes room for grey compound)
b.) Place non-parallel "V" shaped index grooves in wax on reduced mandibular occlusion rim and place Vaseline on wax of opposite arch
c.) Use Bunsen Burner to heat gray compound
d.) Temper the hot compound in 140F water bath BEFORE inserting into patients mouth!!

D. Between second and third appt.

1. Mount mandibular diagnostic casts with occlusion rims
2. Survey diagnostic casts

E. Third appointment

1. RPD Consult
    a.) Draw tentative design. Patient MUST be present
    b.) Get RPD faculty approval and scan tentative design into AXIUM

F. Between third and fourth appt.

1. Complete any needed wax ups
2.Tx plan with group faculty and OHR (if this clinic needed)

* Be sure to complete all Fixed consults before OHR tx plan

G. Fourth appointment

1. Schedule Tx Plan appointment with tx planning faculty and patient
2.Tx plan presentation and acceptance by patient

*Try to schedule this TX PLAN appointment during flex time

H. Fifth appointment

1. If needed: Prep Fixed Survey Crowns

* MUST finish Phase 1 and Fixed work before RPD

I. Sixth appointment

1. After all phase 1 and Fixed work complete, take a second set of diagnostic impressions to determine if RPD is still possible

J. Between sixth and seventh appointment

1. Survey and Design Final RPD

K. Seventh appt.

1. Axial contours and mouth preparations

* Parallel guide planes and then rest seats

L. Between Seventh and eighth appointment

1. Construct Custom Tray for Master Impression

* *After Survey crown cementation (will be more than 7th/8th appt if Fixed is needed)

    a.) Option 1: Stock Metal Trays without adhesive and alginate impression material
    b.) Option 2: Custom tray with elastomeric impression material (PVS) when metal stock trays don't fit patient

*Follow RPD Class Manual for TRIAD custom tray construction

M. Eighth appointment

Supplies:
- Mixing Bowl
- Spatula
- 35 cc Syringe
- Alginate (measure and scoop) or PVS
- Impression tray
- Saliva ejector
- Cheek retractors
- 4x4 gauze to clean patien'ts face
- Disinfectant for impression
- Labeled bag for transport to wet lab to pour up
- Cup of mouthwash
- Patient napkin (2)

At Window:
- Vacuspat Mixing Bowl

1. Take Master Impression
    a.) Custom tray: PVS
    b.) Metal stock tray: alginate

* Very important to pour up casts promptly at this phase!!

N. Between Eight and Ninth appt

1. Survey and Design Master Cast

O. Ninth appt

** An RPD/RPD MUST be mounted prior to framework construction

1. Take another facebow bite registration
2. Pick teeth color and a mold

P. Between Ninth and Tenth appt.

1. Mount the case
2. Write RX (from dispensary)
3. Get a faculty's signature and Cashier's stamp
4. Sent to lab and QA team

Q. Tenth appt.

Supplies:
- High and Low Speed
- Detex spray
- Diamond Burs
- Polishing Burs
- Occlusion ribbon
- Gray Compound
- Hanau Torch/bunsen burner
- PVS impression materials
- Buffalo Knife
- At window;
- Hot Water bath
- Patient safety glasses

1. Metal Framework Try-in
   a.) Adjust occlusion and interferences, and polish
2. Border Mold

** Remember to temper hot compound in water bath at 140ºF

3. Take impression with Open Mouth Technique
   a.) Keep framework in mouth
   b.) Trim impression to internal finish line

R. Between tenth and eleventh appt

1. Pour new cast with metal framework in it

** Get faculty help with this step

2. Make Occlusion rims

S. Eleventh appt.

Supplies:
- Gray compound
- Buffalo Knife
- Hanau torch/ Bunsen burner
- Hot water bath (140ºF)

1. Try in Framework and occlusion rim and adjust VDO
2. Record centric jaw relation
3. Facebow transfer with maxillary occlusion rim
4. Choose teeth shape and color

T. Between Eleventh and Twelfth appointment

1. Write RX, get faculty approval and Cashiers stamp
2. Send case to lab and QA

U. Twelfth appt

Supplies:
- RPD wax spatula kit
- Hanau Torch/ Bunsen Burner

1. Wax try-in
   a. Check cusp intercuspation, occlusion, phonetics, and VDO
   b.) Adjust teeth if necessary

V. Between Twelfth and Thirteenth appt

1. Write RX, get faculty approval and Cashier's Stamp
2. Send case to lab and QA

W. Thirteenth appt.

Supplies:
- Detex
- High and Low Speed
- Polishing Burs

1. Final try-in
   a.) Relieve pressure spots
   b.) Adjust Occlusion
   c.) Give Patient Care Instructions form to pt. (in CD clinic)

X. Fourteenth appt

1. 24-48 hours after delivery

Y. Fifteenth appt.

1. Four days later

Z. Weekly appts. until lesion free

** Credit is given with a min. of 2 weeks and lesion free

Requirements:

1. RPD requirements are: At least 1 RPD completed; 1 RPD worked up.
2. These need to be 2 separate patients.
3. If the RPD completion patient needs both upper and lower RPDs, both need to be completed to receive credit.
4. The RPD work up patient may NOT be transferred to another student in a given year for the 1 RPD completed requirement.
5. It is advisable to complete survey crowns on the RPD work up patient, but not required.

1. Tilt
2. Tripod with 0.03 undercut gauge
3. Find undercuts
4. Mark
5. Survey

i. Brown – metal
ii. Blue – acrylic resin
iii. Red – interferences
- Used to tripod with a blue circle around it
iv. Lead – special instructions (F, WW, survey)

Clasp Assembly: DR, reciprocal component, rest, minor connector

TOOTH SUPPORTED RPD'S (KENNEDY CLASS III AND IV)

– support from abutment teeth at each end of edentulous space

A. Clasp assembly at each end of edentulous space
B. Place direct retainers so that the retentive tips are as far away from each other as possible (in front of and behind the fulcrum line, ideally)
C. Clasp Circumferential is clasp of choice
D. Rests – placed on teeth abutments next to or near each edentulous space
E. Retention – placed either Buccal-Buccal or Lingual-Lingual, do not mix the 2. Retention can be on different teeth, just make sure t is on the same surface of each side of the arch
F. Facings if...
I. Large bony undercuts
II. Deep vertical bite
III. Spacing is a problem
IV. Single tooth replacements in anterior
V. Esthetics ridge loss not extensive
VI. No long span (6 teeth or less)
G. Tube tooth if...
I. Single tooth edentulous space in anterior without a deep vertical overbite present
II. Single posterior tooth where you want the esthetics over a metal tooth or facing
III. Vertical space that is reduced
H. Metal Tooth if...
I. Small space between teeth and there is not sufficient space to place the retentive mechanism of a tube tooth or get esthetics from a facing
II. Larger space in posterior and no need to worry about esthetics

Kennedy Class III

A. Unilateral edentulous area with natural teeth remaining both anterior and posterior to it
B. No need for indirect retainers
C. Usually uses a palatal strap when the edentulous spaces are in the posterior and are short span edentulous areas
D. Can use an anterior-posterior palatal bar major connector (can be used with any classification)
I. Hole must be at least the size of a nickel
II. When dipping down, avoid marginal gingiva by minimum of 6mm on a maxillary and 4 mm on mandibular
E. CC is clasp of choice
F. A WW may be used
G. Try and get undercuts as far away from each other as possible
H. Will have 4 direct retainers
I. Maxillary canines – cingulum rest
J. Mandibular canines – DI angle rest
K. Facings – maxillary (metal on L and occlusal)
L. TT – all white
M. Reciprocal component – above survey line
N. Mandibular – C-clasp (DB), ring clasp (ML), I-bar
O. Facings – maxillary
P. Tube tooth – 1 spot posterior
Q. Base attachment - >1 tooth anterior/posterior

Kennedy Class IV

R. Single, but bilateral (crossing midline) edentulous area located anterior to remaining natural dentition
S. No need for indirect retainers – although some

rests may act as indirect retainers to prevent rotation of base attachment area from rotating around fulcrum

T. Need retention anterior to and far away from the fulcrum line

I. The greater the distance between the 2 points of retention, the more stable the prosthesis

U. CC is clasp of choice

V. Buccal – retention arm (below survey line for retention)

W. Lingual – reciprocal arm (above survey line)

X. Facings – not more than 6 teeth, anteriors only (DON'T use on mandibular)

Y. Maxillary and mandibular use base attachment

A. Mandibular base plate – 1-2mm above lingu2 al frenum

DISTAL EXTENSION RPD'S (KENNEDY CLASS I AND II)

– support from tissues underlying the base and to a limited degree from the abutment teeth

A. Place direct retainers on abutments next to edentulous areas (into undercut)

I. 1/3 below and it turns upward

a. Terminal 1/3 below survey line and in gingival 1/3 of tooth

b. Tip no higher than middle 1/3 of tooth

c. First 2/3 of clasp arm must be above survey line

II. Begins larger at its origin and tapers as it goes into terminal 1/3

III. If you must go below the survey line before the terminal 1/3, you must note a modification of the survey line

B. Reciprocal component (above HOC)

I. Placed on the middle 1/3 of the tooth placement

II. If it goes below the survey line, the tooth must be altered

III. It must be about the same width from start to finish

IV. The top of the modification line just above the existing survey line. The bottom of the modification line is just below the position you want for the bottom of the new survey line?

C. A rigid clasp (cast circumferential) can be used on the posterior abutment

I. Separate retention as much as possible

D. A rigid clasp (cc) or a flexible clasp (ww) may be used on the anterior abutment

I. Look at position of undercut, root form, root length, and perio condition of abutment to determine if a CC or WW

E. Clasping systems for Class I and II Extension base area

I. RPI system (preferred)

a. Rest – mesial

b. Distal proximal plate

c. Dip on lingual (3mm) and 5mm between dip and major connector

d. I-bar (clasp of choice on extension base RPD)

i. Engages 0.01 undercut and goes up to the survey line

ii. 0.01 midfacial undercut

iii. 2x3mm pod on tooth

iv. 3-4mm straight down from tooth

v. Curve to 6mm below tooth

e. Used when 0.01 midfacial undercut and no contraindications

II. Modified T-Bar

a. Mesial rest

b. Distal guide plate

c. Mmodified T-bar

d. Dip on lingual

e. Used when 0.01 disto-facial undercut and no contraindications

III. Wrought Wire

a. Mesial rest

b. Distal guide plate

c. Wrought wire

d. Used when 0.02 mesio-facial undercut exists and periodontal problems exist

IV. Combination clasp

a. Wrought wire

b. Distal rest

c. Lingual arm or lingual plate

V. Reverse circlet clasp or interproximal ring

a. Mesial and distal rest

b. Distal proximal plate

c. Cast direct retainer to the distofacial 0.01 undercut

d. Dip on lingual

e. Used when 0.01 DF undercut exists and the I-bar, conventional bar clasp,

or WW is contraindicated
f. This should not be used on Maxillary Premolars because it is unaesthetic

VI. Hairpin or Reverse Action Clasp
a. When undercut lies cervical to origin of direct retainer
b. Used in a 0.01 DF undercut on distal extension RPD
c. Used when conventional bar is contraindicated
d. Mesial rest
e. Dip on lingual
f. Proximal plate

VII. Cast circumferential
a. Last choice
b. If only 0.01 undercut exists on MF of premolar
c. Mesial rest
d. CC to MF 0.01 undercut
e. Dip on lingual
f. Distal proximal plate

VIII. Interproximal ring (least desirable)
a. Mesial embrasure rest
b. Distal buccal direct retainer
c. Lingual reciprocal arm
d. Distal guide plate

F. Indirect retainer
I. Must be located as far as possible away from distal extension base or fulcrum

G. Mandibular Major Connector
I. Lingual bar is preferred if there is 8mm of space and no periodontal disease of anteriors
a. Except when #22-27 or less are present (avoid marginal gingiva by 3mm and bar has to be 5mm wide; would not have plating)
II. If less than 8mm of space exists between floor of mouth and marginal gingiva, the lingual plate is indicated

H. Acrylic resin should cover the retromolar pad and extend into the retromylohyoid fossa for potential retention of the posterior flange

Kennedy Class I

A. Bilateral edentulous areas located posterior to remaining natural teeth
B. Indirect retainers on prepared rest seat that provides vertical support
C. Base attachment (minor connector)
I. On mandibular, it extends 2/3 the distance from the distal abutment tooth to the beginning of the retromolar pad (<25mm) with cast stop on crest of ridge
II. On maxillary, it extends into the hamular notch (horseshoe or U-shaped major connector would require cast stops on posterior, but an anterior-posterior palatal strap would not)
D. Maxillary major connector
I. Anterior posterior palatal bar or strap or the palatal plate
E. Direct retainers in cervical 1/3, 0.02 undercut WW
F. I-bar, M-rest, distal proximal plate – premolar abutment
G. Use anterior posterior palatal bar (5-6mm width, 8mm from soft palate, go around ruggae)
H. Mandibular –base attachment; metal at anteriors that connect to I-bar. Then base attachment that covers retromolar pad. Metal in base attachment 2/3 way to retromolar pad that covers crest of ridge of teeth. Put a tissue stop in the posterior and a circle for the tooth. Then dotted blue line near metal that goes over anteriors. Plate anteriors as well.

Kennedy Class II

I. Unilateral edentulous area located posterior to remaining natural teeth
J. Indirect retainer usually placed close to perpendicular drawn to fulcrum line
K. Primary abutments are 2nd molar and canine next to free end side
L. Secondary abutments are canine or first premolar for aesthetics
M. Mandible major connector (lingual bar) – width of car is at least 4-5mm; superior border at least 3-4mm from gingiva; lingual plate used if less than 8mm of space between gingival margin and functional floor
N. Maxillary major connector – anterior-posterior palatal strap

Complete Dentures

Building Blocks Of Removable Appliances

CD

- Diagnostic Impressions
- Pre-prothetic CD Form In Axiium
  - Tuberosity reductions?
  - Tori removal?
  - Alveloplasty?
  - Other?
- Does the patient want an Interim Denture?
- Determine where the teeth will be extracted
  - DMD Oral Surgery
  - OMFS
- ACB Consult Form and Code (if indicated)
- Treatment Plan
- If Interim - extract maxillary posteriors or extract all wait for healing 6 – 8 weeks (have patient back in 1 month to check)
- Step Card
- Primary Impressions
- Custom Trays
- Border Mold
- Master Impressions (with Polyether)
- Base Plates and Occlusion Rims To record
  1. Maxillary plane of occlusion
  2. Lip support
  3. Midline
  4. VDR/VDO
  5. CJR
  6. Post Dam
- Facebow
- Select Teeth and Shade (IPN/Portrait)
- Mount the case on Whip Mix
- Write Lab Rx
- Wax Try-in

Interim

- Diagnostic Impressions
- Pre Prosth CD Form
- Determine where the teeth will be extracted
  - DMD Oral Surgery
  - OMFS
- ACB Consult Form and Code (if indicated)
- Treatment Plan
- Extract maxillary posteriors and wait for healing 6 – 8 weeks (have patient back in 1 month to check)
- Step Card
- Master Impressions (with alginate)

If mandibular teeth remain:

- Base Plates and Occlusion Rims To record
  1. Maxillary plane of occlusion
  2. ~~Lip support~~
  3. Midline
  4. VDR/VDO
  5. CJR
  6. Post Dam

If no mandibular teeth remain:

- Maxillary Base Plate and Occlusion Rim only To record
  1. Maxillary plane of occlusion
  2. ~~Lip support~~
  3. Midline
  4. ~~VDR/VDO~~
  5. ~~CJR~~
  6. Post Dam

- Facebow
- Select Teeth and Shade (3 molds and 3 shades – Bioblend)
- Mount the case on Whip Mix
- Write Lab Rx
- Extract remaining maxillary anterior teeth and deliver Interim

"Flipper"

(Interim RPD)
(Mandibular interim RPD is not a common procedure at ULSD)

- Diagnostic Impressions
- Pre Prosth CD Form
- Survey Cast
- Have Tenative Design Form approved by faculty and scanned to Axium
- Determine where the teeth will be extracted
  - DMD Oral Surgery
  - OMFS
- ACB Consult Form and Code (if indicated)
- Treatment Plan
- Step Card
- Master Impressions (with alginate)
- Base Plates and Occlusion Rims (if indicated) (to mount the case)
- Facebow
- Select Teeth and Shade (IPN/Portrait)
- Mount the case on Whip Mix
- Write Lab Rx
- Extract and deliver Flipper

RPD

- Diagnostic Impressions
- Pre Prosth CD Form
- Survey Casts
- Have Tenative Design Form approved by faculty and scanned to Axium
- Determine where the teeth will be extracted
  - DMD Oral Surgery
  - OMFS
- ACB Consult Form and Code (if indicated)
- Treatment Plan
- Extract and wait for healing 6 – 8 weeks (have patient back in 1 month to check)
- Step Card
- Primary Impressions
- Survey Casts
- Have Final Design approved by faculty (on Step Card???)
- Custom Trays (if indicated, otherwise use a stock tray)
- Border Mold (if indicated)
- Prepare rest seats and guideplanes
- Master Impressions (with alginate)
- Base Plates and Occlusion Rims (to mount the case)
- Facebow
- Select Teeth and Shade (IPN/Portrait)
- Mount the case on Whip Mix
- Write Lab Rx
- Framework Try-in
- Wax Try-in

Appendix

Clinic Supplies Available in Window

Affinis impression material
Permite, X-Slow amalgam
Carbocaine 2%, 1:20,000
Carbocaine 3%
Lidocaine 1:100,000
Lidocaine 1:50,000
Marcaine
Septocaine 1:100,000
Bleaching Kit – Opalescence
Caries Finder
Cavitron
Composi-Tight Matrix system
Crown Forms
Discs, Pop-On
Dri-Angles
Dycal
Enhance Composite Polishing System
Fermit N
Finishing and Polishing Strips
Floss, Glide
Floss – POH
Floss – Unwaxed
Freegenol Temporary Cement
Frigi-Dent Pulp Tester
Fuji II LC Capsules (A1, A2, A3, A3.5, B3, C2)
Fuji Plus Conditioner
Garrison Wedges
Gold color Temporary Crowns
Gutta Percha
Hibiclens
Impregum Impression
Ion Crowns
IRM
Ivoclar EvoCeram Composite
Jeltrate
Jet Acrylic
Lightening Strips
Matrix, Cure-thru
Matrix, Tape
Mouth Props
MQ Lubricant
Occlude
Pain Free desensitizer
ParaPost XP
Paracore
Parapost
Perioguard
Pip (Pressure Indicator Paste)
Pogo Polishing
Polishing points
Prevident 5000
Prevident Varnish
Prophy Angles (disposable)
Prophy Paste
Pumice, Preppies
Purevac solution
Rely X Luting Plus
Rely X Unicem
Shim Stock
Sof Lex Strips
Solvent, Orange
Squeeze Cloths
Tin Oxide
TMS Link Pin kits
Toffelmire bands
Ultraseal XT
Vaseline
Vitrebond
Wedges

XP Bond
Zinc Phosphate Cement, Fleck's
Ziroxide Prophy Paste

Prescription Writing

All written prescriptions should include the following:

- Date of issue.
- Patient's full name, address, and date of birth.
- Prescriber's full name, address, telephone number, DEA number, and signature.
- Drug name, dose, form, and amount.
- Directions for use.
- Refill instructions.

Fluoride Rx's

FLUORIDE PRODUCTS

Systemic Fluoride Drops

Rx: Fluoride oral drops – 0.5 mg/mL (Pediaflor)
Disp: 50mL bottle with 1mL dropper
Sig: Place 1 (2) drop/s p.o h.s q.d. and swallow
RF: Three (3)

Systemic Fluoride Tablets

Fluoride oral tablets – 0.25mg tablets
Disp: 100 chewable tablets
Sig: Take 1 (2,3,4) tablet/s p.o. and chew h.s. q.d. and swallow
RF: Three (3)

Topical Fluoride Rinse

0.2% neutral sodium fluoride rinse (prevident rinse – 900 ppm)
Disp: 240 mL bottle
Sig: Rinse with 10mL for 2 minutes h.s. and expectorate q.d. Nothing p.o. following for 30 minutes
RF: Three (3)

Topical Fluoride Paste

1.1% neutral sodium fluoride paste (prevident paste – 5000 ppm)
Disp: 1.8 ounces (51 grams)
Sig: Brush with pea-sized amount for 2 minutes h.s. and expectorate q.d. Nothing p.o. following for 30 minutes
RF: Three (3)

Topical Fluroide Gel

1.1% neutral sodium fluoride gel (prevident gel – 5000 ppm)
Disp: 2.0 ounces (56 grams)
Sig: Brush on gel h.s. q.d. Nothing p.o. following for 30 minutes
RF: Three (3)

Rx Abbreviations

Abbreviation	Description
ad lib.	Freely, as needed
a.c.	Before meals
b.i.d.	Twice a day caps – Capsule
gtt.	Drops
h.s.	At bedtime
p.c.	After meals
p.o.	By mouth
p.r.n.	As needed
oint	Ointment
qAM	Every morning
a.4.h.	Every four hours
q.d.	Daily
q.h.s.	At bedtime
q.i.d.	Four times a day
q.o.d.	Every other day
sol	Solution
susp	Suspension
t.i.d.	Three times a day
top	Topically
ung	ointment
Ut diet, UD	As directed

Salivary Rx's

SALIVARY SUBSTITUTES

Oral Systemic Medications

Rx: Pilocarpine (5mg) Salagen
Disp: 100 tablets
Sig: Take 1 tablet t.i.d. for dry mouth
RF: Three (3)

or

Cevimelin HCL (15mg) Evoxac
Disp: 100 tablets
Sig: Take 1-3 tablet/s t.i.d. for dry mouth
RF: Three (3)

Oral Topical Medications

Glucose oxidase and lactoperoxidase (Biotene)
Disp: 120 mL
Sig: Rinse with 10mL for 1 minute p.r.n. for dry mouth
RF: Three (3)

Antimicrobial Rx's

ANTIMICROBIAL RINSES

Topical Oral Rinse

Chlorohexadine gluconate – 0.12% (Peridex)
Disp: 480 mL
Sig: Swish 1 teaspoon for 1 minute and expectorate h.s. q.d.
RF: Three (3)

Side Note: Expectorate is a fancy way of saying "spit out"

Clinic Staff Information

General D3 Clinic Information from the Clinic Staff

- If you need to be absent from clinic, call Patients Service Representatives – PSR (scheduler at the front desk) at and Student affairs at 852-5081.

- You will be given a student no show if the staff does not hear from you. Any missed rotation time will need to be made up.

- Time off must be requested with a Student Request for Leave Form

- When time is requested off during a rotation, a Rotation Change Form must be completed and taken to the rotation for signature. If there is no available substitute exists, someone in each rotation clinic will determine if the absence can be excused without a sub or if you will need to be find someone to cover the rotation.

- All appointment must be planned. No exceptions.

- When you need an appointment put in your schedule see or a-mail your Team Coordinator. If you Team Coordinator is unavailable, please see one f the PSRs at the second floor reception. If another patient is already in your schedule at the time you are requesting, the patient originally schedule will keep the appointment time.

- Patients should not be given an appointment card until the appointment is scheduled in axiUm. The schedulers are trying to avoid double booking. If it is at the end of a clinic session, and no one is in the clinic to schedule for you, tell the patient you will call them to confirm the appointment once you have it in your schedule- Do Not Give An Appointment Card.

- Appointments cannont be changed unless they are approved by your Team Coordinator or the Office Manager, Debbie Wright.

- If you need help contacting your patient, work with your Team Coordinator

- It is your responsibility to stay on top of your Medical Consults and review them in a timely manner

- At the end of each clinic session, make sure your cubicle is clean, the unit is turned off, and the bottles are removed and drained.

Important Phone Numbers:
Debbie Wright (Office Manager) 852-2125
Therese Hayden (Patient Care Coordinator)852-7114
A-1 Amanda Kline 852-5606
A-2 Gina Risinger 852-0198
B-1 Brenda Klements 852-0278
B-2 Lilia Lawson 852-0582
C-1 Cindy Masticola 852-0594
C-2 Lisa Mason 852-6861

Patient Service Representatives (2nd Floor)
Sara Riley 852-6414
Sue Shaw 852-2135
Nancy Trabue 852-1289

Assistants: Jayne Giannini & Lisa Gutermuth

Remember! If going to be absent from clinic unannounced, call 852-2135 & 852-5081

Other Office Numbers:
Billing Office 852-510
Engineering 852-4183

Internal Administrative Codes

Code	Procedure Description
0010	Student No Show
0019-03	Nametag
0020	Patient No Show
0021	Patient Cancellation
0022	Student Cancellation
0040	Review, Preventative
0040-02	Review, Restorative
0040-03	Review, Perio
0041	Completed Case (closes tx plan)
0044	Return for further tx plan
0047	Treatmen plan presentation
0047-01	Treatmen plan presentation – Limited tx
0047-02	Treatmen plan presentation – Emergency tx
0051	OD/OM Consult
0056	Recement Temporary Crown
0060	Orthodontic Consult, DMD
0076	Endodontic, Recall
0080	Perio Exam/Initial
0082	Perio Observe Surgery
0083	Perio Surgery Post-Op
0084	Perio Re-eval
0087	Remove Casting
0093	Consultation
0094	Observe/Evaluate
0095	Exit Interview
0105	Caries Risk Assessment (Initial)
0105-01	Caries Risk Assessment (Periodic)

Axium Notes

Narrative Note- Comprehensive Exam

- Template Note (medical/dental history narrative)
- CC
- HCC
- MH
- Significant medical problems and meds
- Hospitalizations/surgeries (if significant)
- Allergies
- FHx
- SHx
- DHx
- Today's procedures
- Next visit

SOAP Note- Emergency Exam

- General Note
- Subjective- the patient's report; symptoms
- Includes the CC and HCC
- Objective- what the dentist sees; signs
- Significant MH, meds, allergies, vital signs, intraoral and extraoral exam, any tests and findings
- Assessment- diagnosis
- Plan- what should be done and what was actually done

PARTS Note- Every other appointment

- Use general note
- P- problem, or reason the service is being rendered
- A- Assessment of the patient (current health status, vitals, signs and symptoms related to current problem)
- R- Prescriptions or recommendations
- T- Treatment rendered
- S- Strategy (plan for next visit)

Contact Note- Every time contact is made (phone)

- Every time the patient is called about appointments or follow-ups a note is added in the patient card

Consult Note- Medical consults

- Every time a medical consult is returned a summary of pertinent information and faculty comments are added

Rubber Dam Clamp Quicklist

CLAMPS:

#9: For Anterior Teeth – usually single tooth isolation
#2: Premolars
Double 00: Small Premolars, Incisors or Deciduous
#7: For Lower molars
#8: Universal upper molar clamp

14A & 8A: for partially erupted molars of various sizes

"A" refers to the subgingival design of the jaws of the clamps

Additional molar clamps: W56, 3 & 14
W56- Universal upper and lower molar
3- small mand molar clamp
14- irregularly shaped molars

212 & 2A for structurally compromised premolars

Others: Brinker's Retractors provide retraction and isolation

Names with B#

TECHNIQUES:

Remember to always Ligate the clamp

I. Winged Application technique:
- Dam placed on the frame
- Punch holes
- The projections of the clamp are placed in the hole, this retains the clamp within the dam for an easy and quick simulateous placement

II. Wingless Application technique:
- The clamp is placed on the tooth first (with ligation)
- Dam is stretched over the clamp and tooth into the hole of the dam
- Then both clamp and dam are delivered to the mouth for placement
- Once clamp is seated on the tooth, the dam is stretched over the jaws of the clamp

III. Modified Wing Technique:
- The bow of a wingless clamp is placed

HELPFUL POINTS to REMEMBER:

Wedjet's Stabilizing Cord is an option to aid in retention of the dam without a clamp
Additionally, it works excellently as an anterior holder/stopper

Contacts should always be "Knifed" not Bunched

The loop technique can be accomplished with Waxed floss to help establish contacts
- Essentially floss once to begin to carry the dam interproximally, without removing the floss, use an extended end to floss the dam into the contact again; thus, further pushing the dam into place. Remove the newly create loop of floss by gently pulling both ends of the floos to the buccal.

After securing contact points, Tuck in the edges of the dam that touch teeth under (inversion) Isolation

Removal
- Cut interseptal rubber by pulling the dam away from the teeth and placing my finger along the pts soft tissues
- Remove the clamp and frame
- Then look for missing pieces
- Wipe and dry patient face before dismal!

https://www.youtube.com/embed/OJHQZ44ShbM?rel=0