OFFICE FOR CLINICAL AFFAIRS

Michael Conte, DMD, MPH
Associate Dean

August Pellegrini, DDS
Assistant Dean

Jill York, DDS, MAS
Assistant Dean, Extramural Sites

Kimberly Eames, CDA, RDA
Program Administrator

Celia Garcia
Principal Management Assistant

(open)
Dental Infection Control Safety Technician

Group Practice Administrators:
Janine Fredericks-Younger, DMD
Nathalie Scarpa-Lota, DMD
Jerome Silverstein, DDS
Barry Simon, DDS
Robert Shekitka, DMD

Dental Care Coordinators:
Carol Chrystal
Eneida Martinez
Patricia Perry
Michelle Alvarez

Revised: July 2013
## Administration
- Dr. Michael Conte, Associate Dean (973) 972-1263
- Dr. August Pellegrini, Assistant Dean (973) 972-3257
- Dr. Jill York, Assistant Dean (973) 972-0190
- Kimberly Eames, Program Administrator (973) 972-3625
- Celia Garcia, Principal Management Assistant (973) 972-3247
  - Infection Control Technician (973) 972-2507

## Clinical Affairs, Main Number (973) 972-6679
- Initial Screening Appointments (973) 972-7370

### Group Practice Administrators
- Dr. Barry Simon (973) 972-8603
- Dr. Janine Fredericks-Younger (973) 972-9714
- Dr. Robert Shekitka (973) 972-8806
- Dr. Scarpa-Lota (973) 972-9724
- Dr. Jerome Silverstein (973) 972-9818

### Dental Care Coordinators
- Group A Ms. Carol Chrystal (973) 972-7537
- Group B Ms. Michelle Alvarez (973) 972-7531
- Group C Ms. Patricia Perry (973) 972-7534
- Group D Ms. Eneida Martinez (973) 972-7535
- Dental Record Room (973) 972-4177
- Financial Counseling (973) 972-5303
- Reception Area Seven (Groups A and B) (973) 972-4160
- Reception Area 12th Ave Oral Health Pavilion (Groups C and D) (973) 972-4884

### Other Areas
<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Ambulance Dispatch Center</td>
<td>(973) 972-7000</td>
</tr>
<tr>
<td>Security Desk – B Level</td>
<td>(973) 972-2974</td>
</tr>
<tr>
<td>Security Desk – C Level</td>
<td>(973) 972-2975</td>
</tr>
<tr>
<td>RUTGERS Public Safety – Emergencies Only</td>
<td>(973) 972-4490</td>
</tr>
<tr>
<td>Overhead Paging</td>
<td>(973) 972-3758</td>
</tr>
<tr>
<td>Academic Affairs</td>
<td>(973) 972-4440</td>
</tr>
<tr>
<td>Community Health</td>
<td>(973) 972-3796</td>
</tr>
<tr>
<td>Dean’s Office</td>
<td>(973) 972-4633</td>
</tr>
<tr>
<td>Diagnostic Sciences</td>
<td>(973) 972-4506</td>
</tr>
<tr>
<td>Emergency Care</td>
<td>(973) 972-0335</td>
</tr>
<tr>
<td>Endodontics</td>
<td>(973) 972-4690</td>
</tr>
<tr>
<td>Oral Maxillofacial Surgery</td>
<td>(973) 972-4717</td>
</tr>
<tr>
<td>Oral Medicine</td>
<td>(973) 972-3418</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>(973) 972-4704</td>
</tr>
<tr>
<td>Pediatric Dentistry</td>
<td>(973) 972-4620</td>
</tr>
<tr>
<td>Periodontics</td>
<td>(973) 972-4210</td>
</tr>
<tr>
<td>Privacy Liaison</td>
<td>(973) 972-6608</td>
</tr>
<tr>
<td>Restorative Dentistry</td>
<td>(973) 972-4615</td>
</tr>
<tr>
<td>Special Care</td>
<td>(973) 972-7040</td>
</tr>
<tr>
<td>Student Affairs</td>
<td>(973) 972-5063/5064</td>
</tr>
<tr>
<td>Student Health</td>
<td>(973) 972-8219</td>
</tr>
</tbody>
</table>
INTRODUCTION

As students embark on their final two years of their education at the Rutgers School of Dental Medicine (SDM), this Student Clinic Manual will serve as a communications tool to disseminate the clinical code of conduct regarding the dental school’s operational issues. All individuals governed by these codes of conduct are required to comply with all the provisions and policies as set forth in this document.

The Student Clinic Manual also provides the basis for the Patient Care and Management courses given by the Office for Clinical Affairs. Individuals who do not comply with the policies and provisions of this Student Clinic Manual will receive a notice, warning or failure and could also result in disciplinary action as determined by the Student Academic Performance Committee.

Every student in the Clinic is expected to read the Student Clinic Manual. In early June, every second-year, third-year and fourth-year dental student is expected to have read the Student Clinic Manual as well as the documents listed below. Each student will then sign a form indicating that they have read, understand, and will abide by these documents.

CODE Students are responsible for all policies and procedures as outlined in this Clinic Manual as well as the CODE Supplemental Manual that is part of this document.

Students must read:

- **Code of Professional Conduct and Ethics / SDM Honor Code**
  
  Please refer to the Student Handbook under Part VIII
  
  Available online

- **Health Information Portability and Accountability Act (HIPAA)**
  
  Available online

- **Patient Rights and Responsibilities**
  
  Available online

- **Confidentiality Statement**
  
  Available online

- **Dress Code Policy**
  
  Please refer to the Infection Control Manual under Section XIII: Clinic Attire
  
  Available online

- **Infection Control Manual**
  
  Available online

- **Radiation Safety Manual**
  
  Available online

- **Sterilization Manual**
  
  Available online

- **Point Requirements**
  
  Available online

- **Fee Schedule**
  
  Available on the School’s automatic patient management system, axiUUm.
LOCATION OF: Rutgers School of Dental Medicine

The School of Dental Medicine has clinics located on the Rutgers Newark Campus, accessible from Penn Station via 31 or 34 bus routes.

The Bergen Street Circle, Entrance at:
110 Bergen Street
Newark, NJ 07101-1709

The 12th Avenue Oral Health Pavilion, Entrance at:
Fifty 12th Avenue
Newark, NJ 07101-1709
DIRECTIONS TO: Rutgers School of Dental Medicine

Directions via Garden State Parkway
Take Exit 145 to I-280 East.

Stay left to exit at First Street. Turn right on First St. And continue across West Market Street where First Street becomes Bergen Street.

Go one light past West Market, to 12th Avenue; bear left for Self-parking in Doctors Office Center (DOC) garage.

Directions via New Jersey Turnpike
Take Exit 15W to I-280 to Orange Street/6th Street Exit.

Make the first right onto Orange Street; proceed one block to First Street.

Turn right and proceed about half of mile to West Market St. where First Street becomes Bergen Street.

Go one light past West Market Street to 12th Avenue; bear left for self-parking in DOC garage.

Directions via Route 78 East or West
Take Exit 56, towards Elizabeth Avenue and turn left at Elizabeth Avenue traffic light. At next traffic light, W. Bigelow Street, turn left. Go about three-tenths mile and turn right onto Bergen Street. Proceed about one-and-a-half miles. Cross over South Orange Avenue to the second driveway and turn right towards the DOC self-parking garage.

NOTE: Please see Parking.
PARKING

Patient parking areas are clearly marked throughout the University Complex. It is important that you remind your patients that their vehicle must be parked in an authorized Rutgers Parking Lot, Deck or on the street.

NOTE: Parking is prohibited in any of the surrounding vendor parking lots. (Example: Kentucky Fried Chicken (KFC), IHOP, RiteAid, Blimpies). Vehicles parked in these areas may result in the vehicle being towed at the owner’s expense.
ATTENDANCE POLICIES FOR STUDENTS

The Rutgers School of Dental Medicine considers attendance to be an integral part of the dental education process. Consistent attendance enables the student to achieve the highest level of didactic and clinical competence while providing an increased level of dependable comprehensive care to patients. The responsibility of patient care and personal education advancement requires regular student participation in all didactic and clinical assignments.

1: GENERAL ATTENDANCE POLICIES

1.1 Students are expected to be present for all aspects of the curriculum including all didactic, laboratory and clinical components. Attendance implies arriving promptly at the start of the curricular session and remaining until its conclusion.

1.2 It is understood that there are unavoidable situations, such as illness, accident, or personal circumstance including religious holidays that might delay or prevent a student’s attendance. These allowable absences should not be excessive in number since excessive absence could lead to failure of a course, which could lead to failure of the academic year. Students must make every effort to be in attendance as scheduled. When an absence is anticipated, approval must be obtained in advance by completing a “Rutgers School of Dental Medicine Student Request For Absence (s) Form” and obtaining the appropriate signatures. Forms are available in the Offices of Academic Affairs.

1.3 A student who is absent from school for more than three consecutive days because of illness must be examined by the Student Health Services prior to resuming classes and clinics and provide a statement from a health care provider as well as a release from Student Health Services.

2: DEFINITION OF ABSENCES

2.1 An anticipated absence occurs when the student knows in advance of the absence, that he/she will not be present for a didactic or clinical session.

2.2 An unanticipated absence occurs when the student does not know in advance that he/she would not be present for a didactic or clinical session. (illness, death in family etc.)

3: ATTENDANCE REQUIREMENTS FOR SCHEDULED EXAMINATIONS

3.1. A student is required to take all examinations as scheduled. In the event of illness or circumstances that prohibit taking a scheduled examination, the following policies apply. (Quizzes are exempt from these policies and cannot be made up.)
3.2 **Anticipated Absence**

In rare circumstances, if a student must miss an examination, the student must submit a request in writing to the Associate Dean for Academic Affairs as soon as the student knows the circumstance for the anticipated absence. The Associate Dean will discuss the matter with the course director and inform the student of the decision in the matter. If approved, the student must take a missed examination immediately upon return to school at a time and date set by the course director.

3.3 **Unanticipated Absence**

3.3.A The student must notify the Office of Academic Affairs by telephone by 9:00 am on the day of the examination, and the office will notify the appropriate department.

3.3.B All absences from scheduled examinations must be substantiated by a valid, dated, and written statement elaborating the reason(s) for the student’s absence. The statement must be presented to the Office of Academic Affairs on the first day the student returns following an absence. The written statement and any other documentation supplied will be verified by the Office of Academic Affairs. The Office of Academic Affairs may require additional documentation or other information in order to evaluate the reason for the absence. The student and course director will be notified if the absence is approved or non-approved. If approved, the student must be prepared to take a missed examination immediately upon return to school at a time and date set by the course director.

3.3.C Any absence from a scheduled examination that is not approved by the Office of Academic Affairs will result in an F grade (zero points) being recorded for the examination.

4: **POLICY FOR NONCLINICAL (DIDACTIC AND LABORATORY) COURSES**

4.1 If a student is absent from 30 percent (percentage will be rounded up to the next nearest whole number) of assigned time in a particular course (didactic or laboratory course), the student will be ineligible for tutorials, remediation or reexamination following a failure in a course. Absence due to illness or personal circumstances, unless due to an approved medical leave of absence, is included in the 30 percent total listed above.

5: **POLICY FOR CLINICAL COURSES**

5.1 The Patient Care & Management Courses for the junior and senior academic year have attendance as a requirement. Each course allows for a specific number of absences from open clinic sessions, but does not allow for any absences from scheduled closed clinic session. Each student is allowed 20 sessions (two weeks) of excused absence from the Open Clinic per year. All excused absences over the allotted 20 sessions will be made up, one session for each missed session at the end of the senior year after all academic and clinical requirements have been met,
prior to receiving a diploma. These include absences due to Religious Observances, Academic Deficiencies, Clinical Suspensions or any form of a Leave of Absence. All unexcused absences regardless of the allotted 20 sessions must be made-up two sessions for one session at the end of the senior year after all academic and clinical requirements have been met, prior to receiving a diploma. In extenuating circumstances, a dental student may petition the Associate Dean for the Office for Clinical Affairs for additional excused absences.

5.1.A An **excused absence** is any absence that follows the steps as outlined in the definitions of Anticipated and Unanticipated absences below.

5.1.B An **unexcused absence** is any absence that does not follow the steps as outlined in the definitions of Anticipated and Unanticipated absences below.

5.2. **Anticipated Absence from an Open Clinic**

For anticipated absences from any open clinical session, the student must complete a “RUTGERS – Rutgers School of Dental Medicine Student Request For Absence Form”, and submit it to the GPA prior to the absence occurring. No plans for time off should be made without prior approval by the GPA or the Associate Dean.

5.2.A Absences from Open Clinic for reasons such as **dental meetings, presentations, externships, interviews, continuing education and/or Selective Elective courses** must have prior approval from the GPA. These absences will **not** need to be made-up, but will be considered part of the student’s educational experience.

5.2.B The Office for Clinical Affairs reserves the right to deny a request for absence based on the need to have enough students available to maintain emergency coverage and provide continuity of patient care in the clinical program.

5.3. **Anticipated Absence from a Closed Clinic**

5.3.A For anticipated absences from any closed clinical session, the student must complete a “RUTGERS – Rutgers School of Dental Medicine Student Request For Absence Form”, and obtain the appropriate signatures and approval for the anticipated absences from the Director of the Closed Clinic.

5.3.B Any **excused absence** in a Closed Clinic rotation will be made up one session for one session. Any **unexcused** absence in a Closed Clinic rotation will be made-up two sessions for one session.

5.3.C **Closed Clinics absences** made-up during open clinic time will count as an **excused absence** from the Open Clinic and will be considered part of the allowable absences for Patient Care and Management I or II.
5.3.D Making-up a Closed Clinic session during an Open Clinic session will require the student to complete a “Student Request for Anticipated Absence” Form and to obtain a signature from the Group Practice Administrator. (This session to make up the missed closed session will now count towards the 20 allowed sessions.)

5.4. Unanticipated Absence from an Open Clinic
For unanticipated absences from any Open Clinical session, the student must on a daily basis inform:
5.4.A. The Group Practice Administrator
5.4.B. The scheduled patient(s);
5.4.C. Unanticipated absence must be called in to the GPA or DCC before 9:00 AM or it will be considered an unexcused absence for that clinic session.
5.4.D. If when you call a voice mail picks up you must leave the following information:
   5.4.D.1 The date and time of call.
   5.4.D.2. Student name and ID number.
   5.4.D.3 What will be missed during your absence
   5.4.D.4 The reason for the absence.
   5.4.D.5 Whether scheduled patients were contacted
   5.4.E.6 The GPA will monitor patterns or trends in unanticipated absences.

5.5. Unanticipated Absence from a Closed Clinic
For unanticipated absences from any Closed Clinical session, the student must on a daily basis inform:
5.5.A Their Group Practice Administrator
5.5.B. The director of the closed clinic
5.5.C. Unanticipated absences must be called in to the GPA or DCC before 9:00 AM or it will be considered an unexcused absence for that clinic session.
5.5.D. If when you call a voice mail picks up you must leave the following information:
   5.5.D.1 The date and time of your call.
   5.5.D.2. Student name and ID number.
   5.5.D.3 What will be missed during your absence
   5.5.D.4 The reason for your absence.
   5.5.D.5 Whether scheduled patients were contacted (if applicable)
   5.5.E.6. The GPA will monitor patterns or trends in unanticipated absences.

6: RECORDING OF ATTENDANCE

6.1 Absences are recorded by the Group Practice Administrator and the Dental Care Coordinators.
6.2 Students must take part in a clinically relevant experience as determined by the Group Practice Administrator (GPA) to be considered present for a session. Only clinical experiences approved by the GPA will count toward attendance in the open clinic. Clinical experiences may include: direct patient care, treating a referable/emergency patient, completing an exercise on a manikin, periodontal
surgical assist and assisting in any area of the school that is in the need of assistance. (For example, Intake Center, Emergency, Radiology, etc.) Lab work could be considered at the discretion of the GPA.

6.3 If a student does not have an appointment with an assigned patient, then the student must identify activity for that session on the attendance sheet. The student must also contact the GPA or the DCC for possible assignment to an emergency or referable patient.

6.4. **The student must not leave the clinic area without the permission of the GPA.**

6.5. A student’s attendance at group meetings and general clinic meetings is **mandatory**. Failure to be present will be recorded as a one-session absence from the open clinic.

6.6 If a student has completed all clinical assignments but has exceeded the allotted number of excused absences from the Open Clinic, thereby jeopardizing the student’s chance to start a residency program, a committee composed of the Department Chairs and the Associate Dean for Clinical Affairs will be convened. This committee will deliberate the Student’s attendance requirement.

   6.6.A. Under no circumstances will a student be allowed to graduate with unresolved unexcused absences.

**General Attendance Policies**

1. Students are expected to be present for all aspects of the curriculum including didactic, laboratory and clinical components. Attendance implies arriving promptly at the start of the curricular session and remaining until its conclusion.

2. It is understood that there are unavoidable situations, such as illness, accident, or personal circumstances including religious holidays that might delay or prevent a student’s attendance. These allowable absences should not be excessive in number since excessive absence could lead to failure of a course, which could lead to failure of the academic year. Students must make every effort to be in attendance as scheduled.

3. These attendance requirements apply to all aspects of the curriculum. Exceptions to this policy include scheduled curricular experiences, such as attendance at a professional meeting, extramural rotation, postgraduate program interview, approved curricular accommodation or an approved medical leave of absence (refer to section of the Student Handbook.) All exceptions require appropriate documentation in advance and approval by the Associate Dean of Student Affairs.

4. Third and fourth-year students who must leave school during the day or are absent from school because of illness or personal emergency must notify their Group Practice Administrator (GPA), any open clinic scheduled patients, and the office of any closed clinic assignment, if applicable. (Please refer to page 2 of this manual for telephone number.)

**N.B. Attendance Policy for CODE II Clinical Rotations**

Patient Care & Management I and II require students to be present for all clinical work. All excused absences will be made up two for one. All make ups will be completed at the site you were assigned prior to receiving your diploma and at your expense. Therefore, it is imperative that you make every attempt to be present for each session of your CODE II Clinical Rotation.
BECOMING A PATIENT AT SDM
A patient brochure is available which contains the following information.

Working Together
In order to service your adult dental needs (age 13 and over) we must evaluate your oral health. Call (973) 972-7370 to make an appointment for such an evaluation. The screening examination may be scheduled either in the morning or afternoon, Monday through Friday, at the registration desk on C-level near Radiology of the SDM, 110 Bergen Street. Once your evaluation is completed, you will have radiographs (x-rays) taken and be advised of your dental needs and which services dental students in the Predoctoral Student Clinics can be performed under the direct supervision of experienced and licensed clinical faculty. Your treatment generally will require more of your time than is normally experienced in a private office. A time commitment of three hours per treatment session is therefore needed.

Commitment
We, the faculty, students and staff are glad you have chosen us to provide you with your dental care. The SDM has been serving the communities of this state for over 40 years and we’re proud of our reputation of excellence and commitment to education and service.

Child Patient
Pediatric dental care for children (under age 12) can be obtained by calling (973) 972-4620. Once the initial examination is completed, weekly appointments with a postgraduate resident are made.

Emergency Patient
Treatment for Emergency Care patients is offered on Monday through Friday at 8:00 a.m. and at 12:00 pm at 110 Bergen Street registration desk on C-level of SDM.

Faculty Practice Patient
The School’s Faculty Practice, Center for Dental and Oral Health, is a group practice of dentists with the highest skills. They are the teaching faculty of the Rutgers School of Dental Medicine located at 90 Bergen Street, Room 7700, Newark, NJ. Fees are comparable to those charged at a private dental office. For information call (973) 972-2444.

Special Care Patient
This program is dedicated to treat patients who present with special needs such as Cerebral Palsy, Down syndrome, Parkinson’s disease, and those who are mentally challenged.

Orthodontic Patient
Dental care for correction of alignment of teeth and jaw in adults and children is available by calling (973) 972-4729. Once the initial examination is completed, appointments with a postgraduate resident will be made by the Orthodontic Department.

Orofacial Pain
Patients with temporomandibular, facial and head pain that are not teeth related are treated in this clinic may make an appointment by calling (973) 972-6613.

Fees
Patients pay for treatment at each visit. Estimated fees will be discussed with patients before treatment begins. SDM assists patients in completing patient insurance forms but does not accept direct payment from insurance companies. If questions should arise, SDM Financial Counselors should be consulted.
DENTAL RECORD ROOM REGULATIONS

SDM has a centralized Dental Record Room for the predoctoral program and most postdoctoral programs. The following are the protocols for dental record requests and the operation of the Dental Record Room:

- Dental records required for a patient visit are requested through the receptionist from the information recorded by the students in the appointment books. The receptionist retrieves the dental records from the Dental Record Room.
- Dental records needed for review by a Group Practice Administrator (GPA), Dental Care Coordinator (DCC) or Financial Counselor are requested by using a “Dental Records for Review Request” form. This form is completed and brought to the Dental Record Room.
- The reception areas have the ultimate responsibility to pick up patient records from the Dental Record Room and to ensure all patient records are at the reception areas each day. A bar code label is affixed to all records for clinical record tracking. All dental records are scanned from area to area using the bar code label.
- All pertinent patient information must be listed in the appointment book, pencil only, 24 hours in advance of the appointment (chart number, patient’s name, discipline and procedure to be performed).
- Students who are aware of a cancellation 24 hours in advance must remove their names and the patient’s name from the appointment book, either in person or by notifying the receptionist.
- Students may only list in the appointment book a patient’s visit that has been arranged with the patient.
- LATE SIGN-UP / LATE CHART REQUEST: The DCC is responsible for requesting and picking up late chart requests that are for patient care only (not for chart reviews). If a student forgets to request a chart/patient record or a change in a patient’s appointment occurs after the dental record list has been submitted, the student will go to the DCC and enter the requested dental record on a “Late Chart Request Form.” The DCC will request late charts. Students must understand that late sign-ups will delay the start of treatment.
  
E-mail Service is available to request a chart for the next day’s 10:00 am session so as not to delay patient care.

For patient appointments scheduled after 5:00 pm for the next day’s clinic session, a student may request a chart via e-mail “SDMlatechartrequestonly.” All e-mailed late chart requests are for clinic treatment only and must be received by the Chart Room prior to 7:30 a.m. These charts will be pulled and delivered to your reception area for your clinic appointment.

- It is mandatory that all patient dental records be returned each day. Under no circumstances may a dental record be held overnight or leave the SDM building. See Chart Tracking Policy.
- All patient dental records must be returned to the reception area from which they were originally requested. If the reception area is closed, the dental record must be returned to the Dental Record Room. Under no circumstances should a dental record be held overnight or removed from the building by any faculty, student or staff member. Every dental record must be returned every day to the Dental Record Room by 5:30 p.m.
• Patient dental records are to be given to the receptionist and not left on the counter. The receptionist receiving the record must scan the bar code that will track the record in the AXIUM computer system. See Chart Tracking Policy.

• Dental records not returned by 4:30 p.m. each day must be placed through the return slot located on the wall to the left of Room C-727 (between the Dental Record Room windows). The individual who has not returned the dental record by the end of the day will be in violation of the Chart Tracking Program. The Office for Clinical Affairs will enforce the penalties associated with the Chart Tracking Policy. All individuals requesting a dental record from the Dental Record Room will be advised of the policy violation through their GPA or DCC. Warning notices in Patient Care and Management will be issued to offending students, as well as enforcing imposed sanctions outlined in the Chart Tracking Policy.

• Any dental record recorded as not being returned the same day will result in no additional records being issued to the offending students, faculty or staff member.

• If a dental record is to be reviewed by a student, it can be requested at the Dental Record Room window on the review form at any time between (8:30 a.m. and 4:00 p.m.) However, the dental record may only be signed out between the hours of 11:00 a.m. and 2:00 p.m. and between 3:00 p.m. and 4:30 p.m. with return of the dental record by 5:25 p.m. When a patient’s appointment is scheduled for the next day, the dental record will not be released for review.

• Only two patient dental records may be signed out for review per day per student. Review dental records will not be issued if the individual is listed as having a non-returned record.

• If a dental record is given to a Financial Counselor, GPA, DCC, the Office for Clinical Affairs, postdoctoral student or another department, a new Patient Encounter Form (PEF) must be generated in the recipient’s name, as well as scan the dental record into the individual taking possession of the dental record. See Chart Tracking Policy, “To take possession of a Chart.”

• The Dental Records Window closes everyday at 4:30 p.m.
<table>
<thead>
<tr>
<th>PATIENT RECORD #</th>
<th>REQUESTOR</th>
<th>WHEN AND WHERE RECORD IS TO BE AVAILABLE</th>
<th>LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ID No.</td>
<td>DATE</td>
<td>SESSION</td>
</tr>
<tr>
<td></td>
<td>Student</td>
<td></td>
<td>A.M.</td>
</tr>
<tr>
<td></td>
<td>Staff</td>
<td></td>
<td>P.M.</td>
</tr>
<tr>
<td></td>
<td>Faculty</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Student</td>
<td></td>
<td>A.M.</td>
</tr>
<tr>
<td></td>
<td>Staff</td>
<td></td>
<td>P.M.</td>
</tr>
<tr>
<td></td>
<td>Faculty</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Student</td>
<td></td>
<td>A.M.</td>
</tr>
<tr>
<td></td>
<td>Staff</td>
<td></td>
<td>P.M.</td>
</tr>
<tr>
<td></td>
<td>Faculty</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Student</td>
<td></td>
<td>A.M.</td>
</tr>
<tr>
<td></td>
<td>Staff</td>
<td></td>
<td>P.M.</td>
</tr>
<tr>
<td></td>
<td>Faculty</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Student</td>
<td></td>
<td>A.M.</td>
</tr>
<tr>
<td></td>
<td>Staff</td>
<td></td>
<td>P.M.</td>
</tr>
<tr>
<td></td>
<td>Faculty</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Student</td>
<td></td>
<td>A.M.</td>
</tr>
<tr>
<td></td>
<td>Staff</td>
<td></td>
<td>P.M.</td>
</tr>
<tr>
<td></td>
<td>Faculty</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Student</td>
<td></td>
<td>A.M.</td>
</tr>
<tr>
<td></td>
<td>Staff</td>
<td></td>
<td>P.M.</td>
</tr>
<tr>
<td></td>
<td>Faculty</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Student</td>
<td></td>
<td>A.M.</td>
</tr>
<tr>
<td></td>
<td>Staff</td>
<td></td>
<td>P.M.</td>
</tr>
<tr>
<td></td>
<td>Faculty</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Student</td>
<td></td>
<td>A.M.</td>
</tr>
<tr>
<td></td>
<td>Staff</td>
<td></td>
<td>P.M.</td>
</tr>
<tr>
<td></td>
<td>Faculty</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Student</td>
<td></td>
<td>A.M.</td>
</tr>
<tr>
<td></td>
<td>Staff</td>
<td></td>
<td>P.M.</td>
</tr>
<tr>
<td></td>
<td>Faculty</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Student</td>
<td></td>
<td>A.M.</td>
</tr>
<tr>
<td></td>
<td>Staff</td>
<td></td>
<td>P.M.</td>
</tr>
<tr>
<td></td>
<td>Faculty</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CHART TRACKING POLICY

Objective:
The objective of the Chart Tracking Policy is to track the location of the dental record and ensure accountability by all faculty, staff, and students for the return of all assigned Rutgers School of Dental Medicine (SDM) dental records at the end of each day to the Dental Record Room. All faculty, staff, and students are to understand that when they take possession of a SDM dental record(s), they are solely responsible for each dental record(s) until that responsibility is passed to another faculty, staff or student. A dental record is also known as a chart.

Requirements:
All faculty, staff and students requesting temporary possession of a SDM dental record(s) will require

1. a personal SDM Chart Tracking Bar Code label, which is located on the back of their RUTGERS-SDM identification badge, and
2. a valid e-mail address to obtain a SDM Chart Tracking Bar Code label.

“Request for Bar Code” forms are available in the Office for Clinical Affairs for:

- new hires,
- damaged or faded bar code labels, and
- replacement for lost or stolen ID’s.

A replacement bar code label will not contain the same information as a previous label. Once the Office for Clinical Affairs processes a request for a new bar code label to replace either a damaged bar code or a lost/stolen ID, the School’s AXIUM (Access to Care & Education) information system will no longer recognize the old bar code.

Accountability:
The individual who is the last person the chart is “scanned in” to is the person accountable for that chart.

In the event that an individual has a chart scanned-in to them and hands the chart to a second person without having the chart scanned-in to that person, the original requestor is still responsible for that chart and may be asked to stop their current activity and retrieve the chart.

In the event that an individual has a chart scanned-in to them and hands the chart to a second person without having the chart scanned-in to that person, and the chart is returned and scanned back in to the Dental Record Room, the Dental Record Room now has responsibility for that chart.
To take possession of a Chart:
In order to take possession of a chart, the requestor must have a valid personal SDM Chart Tracking Bar Code label that will be scanned into AXIUM, and have an active RUTGERS E-mail address.

Steps for Scanning:
   a) The requestor’s personal bar code label is scanned once.
   b) Followed by scanning the chart(s) requested.
   c) The “done” bar code on the computer is scanned, which ends the chart transfer transaction.

It is the requestor’s responsibility who is taking possession of a chart/s to ensure that all scanning steps occur, and that chart(s) transactions are completed to ensure that no other charts are accidentally “scanned in” under the requestor’s name. The Office for Clinical Affairs now holds this requestor accountable for all charts “scanned in.”

A chart can be scanned into another faculty, staff, or student at any time. AXIUM computer terminals with bar code scanners are located at reception areas throughout the Dental School. The process for “scanning-in” a chart to another faculty, staff, or student is the same process outlined above. This process must occur every time a chart responsibility changes hands.

Remember, you do not want to be responsible for a chart that is no longer in your possession.

Under no circumstances will a chart be dispensed from the Dental Record Room without being scanned to a specific person.

At the end of each day:
The Dental Record Room is closed at 4:30 p.m. Charts that cannot be returned by that time should be placed in the Dental Record Room “return slot” prior to leaving the building at the end of the day.

   No charts are to be kept overnight outside of the Dental Record Room.
   No Charts are to be taken out of the Dental School Building.

At 8:00 a.m., before any charts are dispensed, the Dental Record Room staff must first
   • “Scan in” all returned charts from the day before.

Sanctions: Students are subject to point violations as per the Patient Care & Management syllabus evaluation criteria.
The Clinic Practice Closed Sessions (CPCS), which includes closed rotations in the following clinical disciplines, begin in the summer session of the Second Year and continue as indicated, until the last week of the Fourth Year.

Second Year
- Oral Surgery (two orientation sessions and two clinical sessions per week)
- Oral Radiology (two orientation sessions and two clinical sessions per week)
- General Dentistry (two sessions during the summer session)

Third Year
- Pediatric Dentistry (two sessions every other week)
- Oral Radiology (two sessions every fourth week)
- General Dentistry (one session every fourth week)
- Treatment Planning Seminar (one session every fourth week)
- Oral Surgery (nine sessions per week for three weeks)
- Screening (8 double sessions per academic year)

Fourth Year
- Oral Surgery (two sessions every fourth week)
- Emergency Clinic (one session every other week)
- Pediatric Dentistry (one session every other week)
- General Dentistry (one session every fourth week)
- Oral Medicine (one session every fourth week)
- University Hospital (nine sessions per week for one week)
- Oral Medicine (ten sessions per week for one week)
- Orthodontics (seven sessions per academic year)

Most rotations are scheduled by group to allow all students in a Group Practice to participate in these assigned clinical activities in the same sessions of a week throughout the year. This enhances scheduling, improves continuity of faculty supervision, and distributes the time assigned to these rotations more equitably.

The time allotted to students in each closed rotation is equivalent to the curriculum hours and course weight for each discipline and not allotted primarily to patient care services.
CODE BLUE MEDICAL EMERGENCY PROTOCOL

Purpose:
To provide a standard procedure for the appropriate management of medical emergencies that may occur at the Rutgers School of Dental Medicine.

CODE BLUE Protocol During School Hours:
The treating dentist or student using the ABC method should support the emergency patient and enlist the help of others to retrieve the emergency medical cart, oxygen and Automated Emergency Defibrillator (AED), if needed, that is stationed in each clinical area. If the faculty or student feels the situation is critical enough (i.e., anaphylaxis, cardiac arrest, stroke), a CODE BLUE should be started as follows:

1. Pick up a Red Emergency phone located near the emergency medical cart, identified by a Red framed sign, in each clinic.
   - This phone is for emergency use only and rings automatically and simultaneously in Clinical Affairs, the OMFS Clinic and the Oral Medicine Clinic.
   - The telephone call will automatically ring in the Department of Public Safety if not answered by one of the above three areas.
   - Give the location of the emergency, floor level, clinical area and unit number.
   - A team is dispatched from the OMFS Clinic and the Oral Medicine Clinic to assist with the emergency.
   - A representative from the Office for Clinical Affairs will respond to assist with crowd control.
   - These instructions are posted by the red phone.

2. What to do when the red phones are not working:
   - Pick up any house phone (office phone) and announce “CODE BLUE” on the overhead paging system.
     - Dial 2-3758 - after the beep – dial *(star) 22 and speak into the handset.
     - Announce the location of the emergency, floor level, clinical area and unit number.
     - Personnel trained in Advanced Cardiac Life Support (ACLS) present in school should immediately proceed to the site of the emergency to assist the treating dentist and/or student.

3. Medical Emergencies in the Pre-Clinic (Simulation Lab)
   - The Pre-Clinic (Simulation Lab) has a Medical Cart and an Automatic External Defibrillator.
   - There is NO Emergency Red Phone System in the Pre-Clinic (Simulation Lab).
   - Using the regular phone call UMD Police at Extension 2-4490 if further assistance is needed.

CODE BLUE Protocol After School Hours:

I. Call UMD Police at Extension 2-4490 – use any house phone (office phone), OR
   - Pick up a Red Emergency phone located near the emergency medical cart, identified by a “Red Framed” sign, in each clinic.
After eight rings, the telephone call will automatically ring in the Department of Public Safety if not answered by one of the following three areas: Clinical Affairs, the OMFS Clinic, or the Oral Medicine Clinic.

Give the location of the emergency, floor level, clinical area and unit number.

**Red Phone, Emergency Medical Cart and Defibrillator Locations**

**110 Bergen Street, Oral Health Pavilion:**

<table>
<thead>
<tr>
<th>Level</th>
<th>Area</th>
<th>Red Phone</th>
<th>Emergency Cart</th>
<th>Defibrillator</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Main Entrance</td>
<td>Security Desk Wall</td>
<td>Near Security Desk</td>
<td>Yes</td>
</tr>
<tr>
<td>C</td>
<td>Bergen St. Entrance</td>
<td>Security Desk Wall</td>
<td>No.</td>
<td>No</td>
</tr>
<tr>
<td>C</td>
<td>Pediatrics</td>
<td>Opposite Bay 3</td>
<td>Opposite Bay 2</td>
<td>Yes</td>
</tr>
<tr>
<td>C</td>
<td>Oral Surgery</td>
<td>Nurses Desk</td>
<td>Operatory 10/11</td>
<td>Yes</td>
</tr>
<tr>
<td>C</td>
<td>Oral Radiology</td>
<td>Wall next to C741A</td>
<td>Panoramic Room</td>
<td>Yes</td>
</tr>
<tr>
<td>C</td>
<td>Emergency</td>
<td>Between Bays 6/7</td>
<td>Between Bays 6/7</td>
<td>Yes</td>
</tr>
<tr>
<td>C</td>
<td>Pre-Clinic</td>
<td>No</td>
<td>Pre-Clinic Lab</td>
<td>Yes</td>
</tr>
<tr>
<td>D</td>
<td>South Clinic</td>
<td>Between Bays 10/11</td>
<td>Between Bays 10/11</td>
<td>Yes</td>
</tr>
<tr>
<td>D</td>
<td>North Clinic</td>
<td>Opposite Bays 22/23</td>
<td>Opposite Bays 22/23</td>
<td>Yes</td>
</tr>
<tr>
<td>D</td>
<td>Oral Medicine</td>
<td>Near Main Entrance</td>
<td>White Cabinets (Kit)</td>
<td>Yes</td>
</tr>
<tr>
<td>D</td>
<td>Special Care</td>
<td>Rear of Clinic</td>
<td>Kit in Reception Area</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Fifty 12th Avenue, Oral Health Pavilion:**

<table>
<thead>
<tr>
<th>Level</th>
<th>Area</th>
<th>Red Phone</th>
<th>Emergency Cart</th>
<th>Defibrillator</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Clinical Affairs</td>
<td>Behind Secretary's Desk</td>
<td>Not Applicable</td>
<td>No</td>
</tr>
<tr>
<td>D</td>
<td>Main Clinic</td>
<td>Opposite end CAP Bay 33</td>
<td>End CAP 33</td>
<td>Yes</td>
</tr>
<tr>
<td>D</td>
<td>Main Clinic</td>
<td>Opposite end CAP Bay 38</td>
<td>End CAP 38</td>
<td>Yes</td>
</tr>
<tr>
<td>B</td>
<td>Main Corridor</td>
<td>No</td>
<td>Opposite Restrooms</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Maintenance of Emergency Medical Equipment**

**Emergency Medical Carts:**
- Crash carts are checked once a month by the Office for Clinical Affairs to ensure all medications are current and not expired.

**Defibrillators:**
- Defibrillators are checked once a month by the Office for Clinical Affairs to ensure the green light is lit on the automatic external defibrillator (AED).
- ReplaxiUmment batteries should be ordered through the Office for Clinical Affairs.

**Logs:**
- A monthly log is maintained by the Office for Clinical Affairs indicating that all medications and equipment have been checked and are operational.

**Red Phones:**
- The Office for Clinical Affairs checks all red phones every other Monday morning.
Medical Emergency Protocol Review:

- Each pre-doctoral student will participate in an emergency medical protocol review twice a year.

IMPORTANT NUMBERS:

EMERGENCY AMBULANCE DISPATCH CENTER (973) 972-7000
RUTGERS POLICE EMERGENCY (973) 972-4490
DEPARTMENT OF ORAL SURGERY (973) 972-4717
OFFICE FOR CLINICAL AFFAIRS (973) 972-6679 or 5304
OVERHEAD PAGING 2-3758 “BEEP” *(star)22
C-LEVEL BERGEN ST. CIRCLE, SECURITY OFFICER (973) 972-2975

NOTE: If a dental patient is referred to University Hospital for emergency treatment, the Office for Clinical Affairs must complete an Incident Report, and according to N.J.-A.C.12-30-8.8, must, within twenty working days, write a letter to the Executive Director of the State Board of Dentistry documenting the details of the incident.
Rutgers School of Dental Medicine
Course Syllabus

COURSE#: CLAF8329, CLAF8429
OFFICIAL COURSE NAME: Patient Care and Management I, II
COURSE DIRECTOR: Dr. August Pellegrini
CONTACT INFORMATION: 973-972-3257
Room: D994
pellegad@Rutgers.edu

ACADEMIC YEAR: 3rd Year, 4th Year
TRIMESTER(s): Fall, Winter, Spring

CREDIT HOURS:
CLAF8329 0
CLAF8429 0

CONTACT HOURS:
Lecture
Seminar/PBL
Laboratory
Clinic 450 (estimated/average)
Hospital
Exams:
Other:
TOTAL: 450 (estimated/average)

DAYS & TIME:
ROOM#:

REQUIRED TEXT(s):

RECOMMENDED TEXT(s):
N/A

COURSE DESCRIPTION:
This course entails group seminars and the delivery of comprehensive patient care consistent to diverse patients.

COURSE GOALS:
The goal of this course is to deliver patient care consistent with the highest standards that bridge all clinical disciplines by providing a setting in which faculty with discipline expertise can interact in formulating a diagnosis, developing treatment plans, delivering treatment and maintaining patients’ health. This course is designed to ensure the integration of social, ethical and humanitarian components through instruction in group seminars and during the delivery of patient care. The SDM Comprehensive Patient Care System (CPCS) has patient care, education, environment and assessment as its focus.
COURSE OBJECTIVES:
Upon completion of this course students will have demonstrated competency in the areas below.

SDM COMPETENCIES TESTED TO:
1. Demonstrate a philosophy to practice within one’s scope of competence making the patient’s well-being the primary goal.
2. Demonstrate compliance with legal and ethical standards in the provision of dental care.
3. Understand the differences in providing oral healthcare to a diverse patient population of all ages including patients with special needs.
4. Apply basic biomedical, behavioral, clinical science knowledge and critical thinking skills to patient care and management including evaluation, diagnosis, treatment or referral.
5. Communicate effectively with peers, patients, staff, and with other health practitioners of ethnic and cultural diversity in a professional and non-judgmental manner.
6. Use behavioral, communication and patient management skills in providing patient care.
7. Use contemporary technology to manage clinical and practice management.
8. Access, retrieve and use data from standard and/or electronic databases.
9. Implement and monitor an effective infection control program in accordance with contemporary guidelines.
10. Understand risk management including confidential and accurate dental records.
11. Recognize the limitations of his/her expertise and request, obtain and interpret necessary medical, dental specialist, or other health care provider consultations.
12. Diagnose and manage odontogenic infections.
13. Obtain informed consent for procedures to be performed.
15. Monitors the outcomes of treatment and modify the diagnosis or therapy as necessary.

SDM COURSE COMPETENCIES TAUGHT TO:
Patient Care and Management contributes to the following Rutgers School of Dental Medicine Competencies for the New Graduate:

1. Demonstrate a philosophy to practice within one’s scope of competence making the patient’s well-being the primary goal.
2. Evaluate and integrate research, clinical expertise and patient values for evidence-based practices.
3. Demonstrate compliance with legal and ethical standards in the provision of dental care.
4. Understand the differences in providing oral healthcare to a diverse patient population of all ages including patients with special needs.
5. Apply basic biomedical, behavioral, clinical science knowledge and critical thinking skills to patient care and management including evaluation, diagnosis, treatment or referral.
6. Communicate effectively with peers, patients, staff, and with other health practitioners of ethnic and cultural diversity in a professional and non-judgmental manner.
7. Use behavioral, communication and patient management skills in providing patient care.
8. Use contemporary technology to manage clinical and practice management.
9. Demonstrate compliance with local, state and federal regulations including OSHA and HIPAA.
10. Understand the scope of practice of allied dental health personnel.
11. Implement and monitor an effective infection control program in accordance with contemporary guidelines.
12. Understand risk management including confidential and accurate dental records.
13. Evaluate different models of oral health care management and delivery.
Obtain, record and interpret a patient’s comprehensive medical, dental, and psychosocial history, including an oral and head & neck exam.

Select, obtain and interpret intraoral and extraoral radiographs.

Select, obtain and interpret diagnostic casts, appropriate laboratory and diagnostic tests or procedures.

Recognize the limitations of his/her expertise and request, obtain and interpret necessary medical, dental specialist, or other health care provider consultations.

Identify predisposing and etiologic factors that require intervention to prevent disease.

Diagnose and manage dental caries.

Diagnose and manage periodontal diseases.

Diagnose and manage pulpal and periradicular pathology.

Diagnose and manage dental esthetics.

Diagnose and manage dental or skeletal abnormalities as they relate to occlusion and spaciUum management.

Diagnose and manage chronic oral-facial pain and temporomandibular disorders.

Diagnose and manage common pathology of the oral/maxillofacial region.

Diagnose and manage oral manifestations of systemic diseases.

Diagnose and manage odontogenic infections.

Diagnose and manage dentofacial injuries.

Diagnose and manage partial and complete edentulism using fixed, removable, and dental implant prosthodontic therapies.

Recognize health conditions that may modify or limit level of treatment and obtain appropriate consultations.

Develop dental treatment plan alternatives that incorporate risks, benefits, prognoses, the patient’s values and procedure sequencing.

Obtain informed consent for procedures to be performed.

Evaluate and manage patient needs in prevention of oral disease and maintenance of oral health.

Select and administer or prescribe the appropriate pharmacological agents to manage infection, pain and anxiety.

Administer intraoral local anesthesia.

Perform intracoronar or extracoronar restorations.

Perform therapeutic procedures designed to preserve the vitality of the dental pulp.

Recognize and manage dental and medical emergencies, including providing basic life support measures.

Monitor the outcome of treatment and modify the diagnosis or therapy as necessary.

COURSE REQUIREMENTS:

Students must pass all competency examinations and maintain a daily clinical activity grade of 70 or higher in order to pass the course.

1. Daily Clinical Activity:
Students must adhere to all policies and procedures in the Student Handbook and all Policy Manuals.

Observation and interactions with all faculty. The daily grading follows a pre-determined criteria sheet which lists point violations and severity, and is summarized as follows:

N Written Notice – Deduction of 5 points
W Written Warning – Deduction of 10 points
M Major Violation - automatic failure – any incident which seriously jeopardizes the safety, health and/or welfare of patients, faculty, staff and/or fellow students. The classification of an incident as a major violation will be determined by a committee of the Associate Dean
2. **Competency Examinations:**
Administered by Group Practice Administrator or Department Director.

The Office for Clinical Affairs oversees competency testing for 6 areas:
- Final Case Review
- Information Systems
- Patient Care & Management Competency
- Special Care Treatment
- Emergency Care
- Patient Video Communications

A. **Final Case Review**
The final case review gives the student the opportunity to assure that all needs of the patient have been met, that new or pre-existing conditions are not present, that all treatment listed on the Patient Encounter Form has been marked appropriately as completed, and that no patient balance remains. Each student is required to complete 10 final case reviews during their 2 year clinical experience, the last to be conducted as a competency. The competency exam may not be conducted on an edentulous patient.

**Required text:** Student Clinic Manual.

**Pre-requisites:** 3rd Year Clinical Orientation Lecture- General Protocol.

**Taken:** During the 2 year clinical experience, after the required 9 final case reviews have been completed.

**Allowable failures before remediation:** Two (2)

**Remediation:** Review of the comprehensive care philosophy and reasoning with the Group Practice Administrator.

B. **Information Systems**
All 3rd and 4th year students are required to ensure that they are proficient with the operation and usage of the school computer system. This allows the student the opportunity to retrieve reports associated with tracking their clinical requirements as well as determining each department’s individual requirements. Additionally, a student uses this system to view their closed rotation schedule. Lexicomp, a software based program, allows students to quickly access information regarding pharmaxiUmuticals, interactions, medical conditions and treatment options, assisting in the delivery of patient care.

**Pre-requisites:** 3rd Year Clinical Orientation Lecture- Information Systems.
- 2 months of system usage during the student’s current year.

**Taken:** In October of the 3rd and 4th clinical years.

**Allowable Failures before remediation:** Two (2)

**Remediation:** System review with Clinical Affairs faculty or Information Technology personnel.
C. **Patient Care & Management Competency Exam**
In addition to daily observation of their clinical behavior by all faculty, all 3rd and 4th year students are evaluated by their Group Practice Administrator to assure competency in the comprehensive delivery of patient care. This evaluation is performed once each clinical year per student.


**Pre-requisites:** 3rd Year Clinical Orientation Lecture- General Protocol.

**Taken:** During each of the clinical years 3 and 4, and administered at the discretion of the Group Practice Administrator.

**Allowable failures before remediation:** Two (2)

**Remediation:** Comprehensive review of Patient Care & Management grading criteria form with Clinical Affairs faculty with emphasis and discussion of areas not successfully challenged.

D. **Special Care Treatment Competency Test**
The goal of the ten session (3 hours per session) Special Care Treatment Module is to provide predoctoral dental students with the clinical experiences needed to allow for competent assessment of the dental patient with special needs. The module consists of one case-based competency examination and one patient based special needs assessment competency examination.

**Taken:** During the senior year after no less than 8 sessions in the Special Care clinical rotation.

**Allowable failures before remediation:** Two (2)

**Remediation:** Students unsuccessful in challenging the competency may reattempt it up to two more times during the clinic rotation. Beyond this, students will be required to repeat the rotation.

E. **Emergency Care Competency Test**
The Emergency/Urgent Care module is a 3 hour didactic, 3 hour clinical orientation and a 21 session (3 hours per session) clinical rotation. The rotation is designed to teach the students the art and science of triage and differential diagnosis as well as how and when to render the appropriate emergency dental treatment when required.

**Pre-requisites:** 3rd Year Clinical Orientation Lecture- Emergency Care, successful completion of 10 direct patient care visits in the Emergency Clinic closed rotation.

**Taken:** Senior year, after the 10th patient is treated and evaluated successfully, the student can take the competency test which is graded as pass/fail.

**Allowable failures before remediation:** One (1)

**Remediation:** The student can remediate by going over the test and the related didactic material with the attending faculty. The student will need to evaluate and treat an additional two patients before taking the competency test again.
F. Video-recorded Patient Communication Competency Test
During one scheduled clinical session students will interview a patient while being video recorded. This recording will be reviewed, evaluated and graded by a licensed therapist and communications expert. The purpose of this exam is to ensure students can competently apply behavioral, communication and patient management skills to diverse patients.

**Taken:** Junior year and Senior year (Class of 2013 only).

**Allowable failures before remediation:** Zero (0)

**Remediation:** The student may remediate by reviewing the grade form and video and then discussing strengths and weaknesses of performance with the evaluator. Once the student has remediated, they are able to challenge the competency again.

To assist students in managing this requirement, the following are specifics with regard to scheduling the patient video recorded interview.

**How To Sign Up:** A sign up log is in plaxiUm at the registration desk in Clinical Affairs. Students will be required to provide their Name and ID #, Patient Name, Day, Date & Time for interview.

**Timeframe:** Recommended Fall Trimester

**Sessions:** 10AM or 11AM

**Location of Patient/Video Recorded Interview:** Open Clinic

**Who:** Ms. Merry Sue Baum, Editor, SDM will record students conducting the interview during the assigned session. Merry Sue Baum phone: 2-3157 email: baumme@Rutgers.edu

**GRADING POLICY:**
Grades will be assigned on a Pass/Fail basis.

- All competencies must be passed in order to pass the course.
- A passing grade of 70 or greater for daily evaluations.

Please note that the spring semester concludes on May 20, 2013. By this date, unless approved by a course director for an “I” (incomplete) grade, fourth year students must complete and pass all competencies, requirements and missed rotations. Failure to do so will result in an “F” grade on the transcript.

**MAKEUP EXAMINATION POLICY:**
Students should follow procedures outlined in the Student Handbook if they are unable to attend a scheduled examination.

**EXAMINATION REVIEW POLICY:**
Students wishing to review results of competency examinations are encouraged to schedule appointments with the involved faculty.

**ATTENDANCE/ABSENTEE POLICY:**
Students are expected to be present for all coursework. Attendance implies arriving promptly at the start of the session and remaining until its conclusion. The student’s responsibility for patient care and personal education advancement requires regular student participation in
clinical assignments. Students must complete attendance requirements for this course prior to graduation. Total absences in excess of 10% of open clinic time for each course, will result in a failure for the course. Under special circumstances a student can petition the course director and the Assistant Dean for Clinical Affairs for additional absences. (Refer to Attendance Policy for Courses I & II).

1. Attendance is a requirement.
2. Students must abide by the Attendance Policy as outlined in the Clinic Manual. The Clinic Manual may be found online.
3. Students must notify their Group Practice Administrator and closed Clinic Director in the event of illness in accordance with the guidelines specified in the Attendance Policy.
4. Students must request permission from the their Group Practice Administrator to be out of the clinic and must notify their Group Practice Administrator of their locations at all times.

CONDUCT, ETHICS & PROFESSIONALISM POLICY:
This course requires students to uphold the SDM Honor Code contained in the SDM Student Handbook. It also adheres to the SDM policy on professionalism fully described in the SDM Student Handbook and requires maintenance of acceptable standards of professionalism. When applicable students may be evaluated using the attached “SDM Professionalism Evaluation Form.”

All students are required to adhere to the Code of Professional Conduct and Ethics as published in the Student Handbook and the policies and procedures listed in the student Clinic Manual and Infection Control Manual.

TUTORIAL and REMEDIATION:
Remediation is issued in accordance with the guidelines set forth in the Dental Student Handbook.

STUDENTS REQUIRING ACCOMMODATIONS:
Any student who feels he/she needs accommodations in order to participate in this course must present a request in writing to the Associate Dean of Academic Affairs. Students are not permitted to make arrangements for accommodations directly with the course director. Course directors will direct all student requests to the Associate Dean of Academic Affairs.
SDM Professionalism Evaluation Form

Date: _______________

Student Name: ___________________ Course: __________________________

Course Director Name: ______________ Signature: _______________________

Reliability and Responsibility
☐ Development of accountable and dependable behavior as it relates to oneself and others
Examples include but are not limited to:
  • Arrival at class on time, and when not, entering the classroom non-disruptively
  • Remaining in class for the full session; taking only necessary breaks
☐ Fulfilling responsibilities and assignments in a timely manner, including but not limited to:
  • Keeping immunizations up-to-date
  • Completing course evaluations
  • Addressing financial obligations

Honesty and Integrity
☐ Representing facts truthfully in all academic, clinical or research situations

Maturity
☐ Taking responsibility for one’s own actions
☐ Providing and accepting constructive feedback, including but not limited to:
  • Providing appropriate feedback on course evaluations
☐ Recognizing limitations and seeking help
☐ Incorporating feedback in order to make changes in behavior

Interactions with Patients
☐ Acting and dressing in a professional manner, including but not limited to:
  • Being sensitive to the needs of and being respectful of patients
  • Establishing and maintaining appropriate boundaries in all learning situations
  • Maintaining HIPPA regulations

Relationships with Students, Faculty and Staff
☐ Conveying respect for other students, faculty, and staff through attitudes, actions, and behaviors. Examples include but are not limited to:
  • Silencing cell phones and pagers in class, laboratory or clinic, and answering only when there is a pending urgent matter
  • Focusing attention on coursework in class, laboratory or clinic rather than attention to other matters (i.e., email/internet, reading materials unrelated to course, or disruptive conversations with others)
☐ Interacting and behaving appropriately with others
☐ Relating well to fellow students, faculty, and staff in the learning environment

Please explain above:

Other feedback (on reverse)
1. Demonstrate a philosophy to practice within one’s scope of competence making the patient’s well-being the primary goal. (Competency 1) Use behavioral, communication and patient management skills in providing patient care. (Competency #7)

<table>
<thead>
<tr>
<th>Student Self-Eval</th>
<th>GPA Eval</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>W, -10 Pts.</td>
</tr>
<tr>
<td>1.2</td>
<td>W, -10 Pts.</td>
</tr>
<tr>
<td>1.3</td>
<td>W, -10 Pts.</td>
</tr>
<tr>
<td>1.4</td>
<td>W, -10 Pts.</td>
</tr>
<tr>
<td>1.5</td>
<td>W, -10 Pts.</td>
</tr>
<tr>
<td>1.6</td>
<td>W, -10 Pts.</td>
</tr>
<tr>
<td>1.7</td>
<td>W, -10 Pts.</td>
</tr>
<tr>
<td>1.8</td>
<td>W, -10 Pts.</td>
</tr>
<tr>
<td>1.9</td>
<td>W, -10 Pts.</td>
</tr>
<tr>
<td>1.10</td>
<td>W, -10 Pts.</td>
</tr>
<tr>
<td>Other</td>
<td>W, -10 Pts./N, -5 Pts.</td>
</tr>
</tbody>
</table>

2. Demonstrates the attitudes and behavioral characteristics of a health care provider who is a caring, competent individual:

<table>
<thead>
<tr>
<th>Student Self-Eval</th>
<th>GPA Eval</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>W, -10 Pts.</td>
</tr>
<tr>
<td>2.2</td>
<td>W, -10 Pts.</td>
</tr>
<tr>
<td>2.3</td>
<td>W, -10 Pts.</td>
</tr>
</tbody>
</table>
and legal risks. \( W, -10 \text{ Pts.} \)

2.4 Treats only registered patients of Rutgers School of Dental Medicine. \( W, -10 \text{ Pts.} \)

2.5 Treats only patients assigned to him/her or referred by the Group Practice Administrator. \( W, -10 \text{ Pts.} \)

2.6 Manage fundamental business and legal matters in the practice of dentistry. (Competency#13) \( W, -10 \text{ Pts.} \)

2.7 Provides treatment only under faculty supervision. \( W, -10 \text{ Pts.} \)

2.8 Is punctual and starts the clinic session promptly. \( N, -5 \text{ Pts.} \)

2.9 Follows the appointment book protocol. \( N, -5 \text{ Pts.} \)

2.10 Follows all clinical policies and rules as outlined in the Student Clinic Manual. \( N, -5 \text{ Pts.} \)

Other 2.11 \( W, -10 \text{ Pts.}/N, -5 \text{ Pts.} \)

3. Monitors the progress and outcomes of treatment and modify the diagnosis or therapy as necessary. (Competency #42)

<table>
<thead>
<tr>
<th>Student Self-Eval</th>
<th>GPA Eval</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Follows proper sequence of treatment as outlined in the Treatment Plan and Patient Encounter Form. ( W, -10 \text{ Pts.} )</td>
</tr>
<tr>
<td>3.2</td>
<td>Recognizes the need to modify the planned treatment in response to the changing oral health needs of the patient. ( W, -10 \text{ Pts.} )</td>
</tr>
<tr>
<td>3.3</td>
<td>Obtains written approval from both faculty and from the patient before changing or modifying the Treatment Plan. ( W, -10 \text{ Pts.} )</td>
</tr>
<tr>
<td>3.4</td>
<td>Recognizes the completion of treatment, fills out a “Final Case Complete” form and sets the appropriate maintenance interval for recare. ( N, -5 \text{ Pts.} )</td>
</tr>
<tr>
<td>3.5</td>
<td>Complies with the patient’s established recare maintenance interval. ( N, -5 \text{ Pts.} )</td>
</tr>
<tr>
<td>3.6</td>
<td>Determine care in the best interest of the patient, rather than to satisfy requirements. ( W, -10 \text{ Pts.} )</td>
</tr>
<tr>
<td>3.7</td>
<td>Monitors patient’s progress and care when another provider is delivering care in another clinic. ( W, -10 \text{ Pts.} )</td>
</tr>
<tr>
<td>Other 3.8</td>
<td>( W, -10 \text{ Pts.}/N, -5 \text{ Pts.} )</td>
</tr>
</tbody>
</table>

4. Implements and monitor an effective infection control program in accordance with contemporary guidelines (Competency #11)

<table>
<thead>
<tr>
<th>Student Self-Eval</th>
<th>GPA Eval</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Maintains infection control standards as recommended by the Office of Environmental Safety. ( W, -10 \text{ Pts.} )</td>
</tr>
<tr>
<td>4.2</td>
<td>Maintains infection control compliance in his/her dental unit. ( W, -10 \text{ Pts.} )</td>
</tr>
<tr>
<td>4.3</td>
<td>Uses only instruments that have been properly sterilized and supplies that have been maintained in a hygienic environment. ( W, -10 \text{ Pts.} )</td>
</tr>
<tr>
<td>4.4</td>
<td>Returns supplies, instruments and equipment to the Clinic Dispensary in accordance with SDM rules and protocols.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>4.5</td>
<td>Uses prescribed personal protective equipment for him/her and for patients.</td>
</tr>
<tr>
<td>4.6</td>
<td>Complies with SDM protocols in the event of percutaneous injury or other potentially dangerous incidents.</td>
</tr>
<tr>
<td>Other</td>
<td>W, -10 Pts. / N, -5 Pts.</td>
</tr>
</tbody>
</table>

5. Communicate effectively with peers, patients, staff, and with other health practitioners of ethnic and cultural diversity in a professional and non-judgmental manner. (Competency # 6)

<table>
<thead>
<tr>
<th>Student Self-Eval</th>
<th>GPA Eval</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Reviews and updates the medical history at every visit. Recognizes the need for and obtains / reviews the medical consult.</td>
<td>W, -10 Pts.</td>
</tr>
<tr>
<td>5.2</td>
<td>Updates vital signs and oral examination status of the patients at the interval determined in the SDM protocol.</td>
<td>N, -5 Pts.</td>
</tr>
<tr>
<td>5.3</td>
<td>Signs in/out promptly and accurately, such that the attendance sheet reflects his/her whereabouts at all times.</td>
<td>N, -5 Pts.</td>
</tr>
<tr>
<td>5.4</td>
<td>Remains in clinic during all sessions until dismissed by the GPA.</td>
<td>N, -5 Pts.</td>
</tr>
<tr>
<td>5.5</td>
<td>Attends all Group meetings.</td>
<td>N, -5 Pts.</td>
</tr>
<tr>
<td>5.6</td>
<td>Prepares for and attend scheduled progress interview meetings with the GPA and DCC.</td>
<td>W, -10 Pts.</td>
</tr>
<tr>
<td>5.7</td>
<td>Complies with the Weekly Monitor Program when assigned by his/her GPA.</td>
<td>W, -10 Pts.</td>
</tr>
<tr>
<td>5.8</td>
<td>Complies with requests and deadlines established by the GPA and/or the DCC.</td>
<td>W, -10 Pts.</td>
</tr>
<tr>
<td>5.9</td>
<td>Obtains informed consent for all procedures to be performed. (Competency #33)</td>
<td>W, -10 Pts.</td>
</tr>
<tr>
<td>5.10</td>
<td>Returns all dental records to the Dental Record Room at the end of each day.</td>
<td>W, -10 Pts.</td>
</tr>
<tr>
<td>5.11</td>
<td>W, -10 Pts. / N, -5 Pts.</td>
<td></td>
</tr>
</tbody>
</table>
Patient Care and Management Evaluation Form

STUDENT’S NAME:_________________  GROUP:  A  B  C  D

SELF EVALUATION:   YES      NO

MAJOR VIOLATION: YES      NO

MAJOR VIOLATION EXPLAINED:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

VIOLATION SECTION:________  VIOLATION NUMBER:________

POINT DEDUCTION:________

FACULTY’S COMMENTS:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Faculty’s Signature __________________________  Date______________

STUDENT’S COMMENTS:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Student’s Signature___________________________ Date_____________

Original-Student       Copy-Office for Clinical Affairs       Copy-GPA
BASIC LIFE SUPPORT, CPR CERTIFICATION

Basic Life Support Requirement
The Commission on Dental Accreditation (CODA) clearly states in Standard 5.5, 
"All students, faculty and support staff involved in the direct provision of patient 
care are recognized in basic life support (BLS) including cardiopulmonary 
resuscitation, and are able to manage common medical emergencies…"

Therefore, all SDM faculty, clinical staff and students (predoctoral, postdoctoral and 
dental hygiene) must have up-to-date certification as set forth by the American 
Heart Association’s Basic Life Support for Health Care Providers. Only CPR 
programs that are endorsed by the American Heart Association that include hands 
on skills evaluation will be accepted by the Rutgers School of Dental Medicine as 
acceptable CPR training. It appears that many CPR testing centers will accept an 
on-line didactic portion of the CPR program, but require that you take your printed 
certificate to a skills testing center for a hands on evaluation. Currently, The 
American Heart Association will only accept their own on-line training prior to 
going to an American Heart Association skills testing center. Presently, CPR 
certification is valid for two (2) years. Failure to maintain this requirement will 
result in loss of clinical privileges.

Medical Waivers
Anyone unable to perform BLS, due to medical or physical limitations, must have 
medical documentation from a physician on file stating why they are unable to 
participate in the hands-on portion of BLS certification training. Anyone who has a 
medical waiver must take and successfully pass the BLS certification written 
examination.

- Student medical waivers - All certification information concerning Medical 
  Waivers for BLS certification is retained in the Office for Student Affairs.

- Faculty medical waivers - All certification information concerning Medical Waivers 
  for BLS certification are retained in each respective department and a copy of 
  this waiver for Clinical Faculty is forwarded to The Office for Clinical Affairs.

Training
First-year dental students will complete their BLS certification during the orientation 
week usually one week prior to matriculation into the fall trimester. These same 
students will be recertified in the spring of their second year as part of a rotation in the 
Clinical Dentistry course. This recertification will allow students to render patient care 
through their fourth year.
Postdoctoral student BLS certification is conducted during orientation in the respective departments. In postdoctoral programs that run longer than 2 years, recertification is required.

In departments such as Oral Maxillofacial Surgery, Diagnostic Sciences and Pediatric Dentistry, residents affiliated with University Hospital must be certified in BLS, as well as Advanced Cardiac Life Support (ACLS). This certification is given by University Hospital.

Newly hired Faculty and clinical staff are required to complete BLS certification or show proof of current certification. BLS Training for recertification is the responsibility of each respective department and faculty and clinical staff are notified about available dates for recertification prior to the expiration of their current BLS certification. In departments such as Oral Maxillofacial Surgery, recertification for faculty in ACLS is scheduled through University Hospital.

**Documentation and Monitoring Compliance**
All certification cards are issued by the BLS Training Center at University Hospital. Certification cards for predoctoral students are forwarded to the Office of Student Affairs where a copy is made for the files and then distributed to the students. Postdoctoral BLS certification cards are forwarded from the BLS Training Center directly to the Director of Postdoctoral Programs for distribution to the Postdoctoral student with a copy sent to the Office of Student Affairs. Records of certification of all predoctoral and postdoctoral students are retained in the Office of Student Affairs to monitor CPR compliance and clear eligible predoctoral and postdoctoral students for patient care.

The BLS Training Center submits BLS recertification cards directly to the faculty and clinical staff. In order to maintain updated records in each department, all faculty and clinical staff must submit a copy of their BLS certification card. Copies of current certification for Clinical Faculty are maintained in the Office for Clinical Affairs.

**Penalties for Non-Compliance**
Faculty, clinical staff and pre-and postdoctoral students who are not in full compliance with the SDM CPR Policy will not be permitted to oversee or render patient care at the Rutgers School of Dental Medicine and will be subject to disciplinary action up to and including dismissal.
STUDENT CLINICAL EVALUATION

Description
The clinical activity and evaluation of the predoctoral students in the Comprehensive Patient Care System (CPCS) are based upon the qualitative delivery of timely and efficient comprehensive care. In the course of treating patients comprehensively, it is expected students complete patient care in accordance with the SDM Comprehensive Care Point System. It should be noted these are guidelines and that student evaluation is based on the comprehensive care of patients.

The CPCS has the following premises:
1. A student is primarily responsible for the total care of each patient assigned. Based upon the needs of a patient, a GPA will consider referral of patients.

2. Fourth-year students are able to complete their clinical program in time to meet University of Medicine and Dentistry of New Jersey policy for participation in commencement exercises.

3. Portfolios of active patients are maintained at a level of approximately 15 patients for third-year students and 20 patients for fourth-year students.

4. SDM makes every effort to provide a pool of patients suitable to meet the experiential needs of each student. However, students are encouraged to attract patients for treatment at SDM.

5. Students must demonstrate competency based upon the quality of care comprehensively delivered to their family of patients.

6. Students are expected to be in attendance during all assigned sessions each week.

7. Closed rotation schedules have precedence over all other schedules.

8. At the end of each clinical year, departments can make recommendations about students to the Student Academic Performance Committee. These recommendations can be any of the following:
   • Incomplete "I", due to illness or military obligation;
   • Failure to demonstrate competency, in which case an "F" is given;
   • Satisfactory demonstration of competency, in which case a letter grade of "C", "C+", "B", "B+", "A" is given. In a pass/fail course a "P" is issued.
9. Students who have failed to demonstrate competency, as defined in the Point System and Competency Assessment Policy of the Clinic Policy Manual, are required to participate in a remediation program during July and/or August. The academic department in which the deficiency occurred, in accordance with the SDM Student Handbook, establishes the length of remediation necessary and guidelines for successful remediation.

Grading Policy for Care and Management Courses
The course grade of Pass/Fail will be based upon the following criteria:

1. Passing grade of 70 or greater for the entire year based upon compliance with the established clinic policies and competencies of the Patient Care and Management Evaluation Criteria Document. The grading protocol will be as follows:
   A. A Patient Care and Management interim grade will be given every trimester for Courses I and II. The interim grade will be either a:
      • S for satisfactory performance (grade 70 or greater); or
      • U for failing performance (grade less than 70).
   B. A Patient Care and Management end of year grade will be given for Courses I and II. The end of year grade will be either a:
      • P for Pass (grade 70 or greater);
      • F for Fail (grade less than 70)
   C. A written notice will be issued for a minor violation as classified by the Evaluation Criteria Document for the Patient Care and Management courses. (Denoted by an N) A written notice will count as a debit of 5 points.
   D. A written warning will be issued for a violation as classified by the Patient Care and Management Evaluation Criteria Document. (Denoted by a W). A written warning will count as a debit of 10 points.
   E. A course failure will be issued for a major violation of the Patient Care and Management Evaluation Criteria Document and/or the Code of Professional Conduct (Article III of Code of Professional Conduct and Ethics – Student Handbook). If there is a breach of ethical standards, the matter will be referred to the Dean who will initiate the review process as outlined in the Student Handbook.

2. Attendance is a requirement for the Patient Care and Management I, Patient Care and Management II. Total absences in the open clinic in excess of:
   • 4 sessions for the Patient Care and Management I Course;
   • 25 sessions for Patient Care and Management II Course;
   (Refer to the Attendance Policy of each course syllabus for details.)

In the Patient Care and Management I and II courses, if a student exceeds absences of seven sessions for a specific trimester, then the student will receive an interim grade of "U" for that trimester. (Refer to the Attendance Policy for remediation in these courses.)

3. Adherence to all policies and procedures in the Student Handbook, Policy Manuals and Point Document.

5. Completion of an AXIUM Software evaluation form.

If a student receives an incomplete grade (I/C) from a clinical department that requires additional open clinic sessions, the student will also receive an I/C grade for the Patient Care and Management Course. This I/C grade will be removed and a final course grade given based on the entire academic year and the extension time once the I/C grade in the clinical discipline has been removed. The student will be required to be present for all weekly open clinic sessions (seven presently) and report to the assigned GPA for treatment of clinic patients until the I/C grade from the clinical department has been removed.

**Evaluation Criteria for Courses I, II:**
- written warning – deduction of 10 points
- M = major violation – automatic failure – any incident which **seriously jeopardizes** the safety, health and/or welfare of patients, faculty, staff and/or fellow students. The classification of an incident as a major violation will be determination of a committee of the Associate Dean for Clinical Affairs, the Director of Patient Resources, and the non-involved GPAs, after a presentation by the student’s GPA.

**Student Evaluation By Clinical Departments**

Students are expected to demonstrate competency in each clinical discipline. Current departmentally-based clinical evaluation criteria are utilized; however, faculty development in standardized student evaluation techniques is in progress and ongoing. The Comprehensive Patient Care System has three general areas by which competency is evaluated:
- Daily clinical activity including knowledge and judgment.
- Designated clinical competency examinations.
- Higher-order cognitive activity demonstrated in case presentations and group practice seminars.

The standard of quality exhibited by a student’s cognitive, psychomotor, and attitudinal performance directly affects the clinical activity expected of him/her.
STUDENT IMMUNIZATION AND HEALTH RECORDS REQUIREMENTS

The Rutgers School of Dental Medicine will strictly enforce the University policy regarding immunizations and health records of students. At the start of each academic year, the Assistant Dean will cross reference the student roster with a compliance report generated by Student Health that includes pre-doctoral, post-graduate and masters programs. Any student found not in compliance will not be permitted to attend classes, rotations or treat patients in the clinical program. Additionally, the Assistant Dean requests bi-weekly reports from Student Health in order to continuously monitor students who may fall out of compliance.

Please review and understand the RUTGERS “Student Immunization & Health Requirements Policy,” which can be found at: http://www.Rutgers.edu/oppmweb/university_policies/student_affairs/PDF/00-01-25-40_00.pdf.
DISPENSARIES

Dispensaries
The Clinical Dispensaries located in South Clinic and at the 12\textsuperscript{th} Avenue Oral Health Pavilion are open from 9:45 \text{ AM} to 5:30 \text{ PM} to service students. The Office for Clinical Affairs employees are responsible for dispensing all clinical supplies utilized by various departments on the D-level. Employees are accountable for the setup of clinical tables containing expendable supplies and the maintenance thereof, as well as the dispensing of expendable supplies for use in the operatories.

Equipment issued from the dispensaries including handpieces, waterbaths, etc. is available as required for the various clinical procedures. The School’s electronic Clinical Identification Tracking System tracks equipment. Students are assigned a bar code label, which is affixed to their RUTGERS identity card. When a student needs equipment, the bar code is scanned and the student is now responsible for this equipment. When the student returns the equipment to the dispensary, the loaned items are scanned back into the dispensary. All items must be returned the same day they are signed out. Under no circumstances is equipment to be passed from student to student. The student is also responsible to ensure that the equipment is clean and in proper working order. Students are held responsible for lost items.

All instruments, handpieces and rotary cutting instruments must be returned at the conclusion of each clinical session to the clinic dispensary from which they were obtained. Contaminated instruments are returned to the “Return Room” in the dispensary from which they were originally scanned out. Contaminated instruments will not be removed from the clinics or kept by students. Students will not be provided with instruments for the treatment of a subsequent patient until all previous instruments, handpieces, rotary cutting instruments and supplies have been returned.

Clinic sessions are scheduled as follows:

\begin{itemize}
  \item Morning 10:00 a.m. to 1:00 p.m.
  \item Afternoon 2:00 p.m. to 4:45 p.m.
\end{itemize}

Dispensary hours for the distribution and return of clinical supplies and handpieces/burs are as follows:

\begin{itemize}
  \item Morning 9:45 a.m. to 1:00 p.m.
  \item Afternoon 2:00 p.m. to 5:15 p.m.
\end{itemize}

Four dental assistants not involved in the distribution of instruments are available each session to provide dental auxiliary utilization (DAU) experiences in Operative Dentistry and/or Fixed Prosthodontics. Their hours are as follows:

\begin{itemize}
  \item Morning 10:15 a.m. to 12:45 p.m.
  \item Afternoon 2:15 p.m. to 4:45 p.m.
\end{itemize}

These four dental assistants assist in closing-up activity from 4:45-5:15 p.m.

If patient treatment requires the delivery of care beyond these very clearly identified times, the following procedures must be initiated:
• Supervising faculty and the GPA must be immediately notified, as they are legally required to be in attendance until the patient has been dismissed. Identification of the need to treat a patient beyond the above referenced times should be made by the student and faculty well before the close of clinic.

• All equipment that is not needed in the care of the patient should be returned to the Dispensing Window dental assistant. At this time any additional material needed to complete the patient should be obtained. Staff will not be available after 5:20 p.m.

• All supplies and equipment must be returned prior to the start of the next session.

| The student is responsible for all supplies and items signed out and are required to return these items to the dispensary prior to receiving any additional instruments. Damaged or lost items are billed to the students. |

The American Dental Association mandates the infection control policies related to clinical care. Everyone works to assist the students in the provision of patient care in a safe environment; however, it is the responsibility of each student to manage clinic time effectively and in compliance with the policies. The Office for Clinical Affairs and the Office of Infection Control and Environmental Safety continuously assesses and monitors infection control policies. Policies and procedures outlined in the Infection Control Manual must be strictly followed. (Please reference the on-line Infection Control Manual.)
BEST MANAGEMENT PRACTICES FOR AMALGAM WASTE

The State of New Jersey has enacted legislation to control and minimize the amount of mercury entering the waste water system by capturing dental amalgam before reaching water treatment facilities. The Rutgers School of Dental Medicine has developed the following guidelines to comply fully with the legislation set forth by the New Jersey Department of Environmental Protection. These guidelines are intended to be utilized in all clinical areas, and where applicable, all pre-clinical areas of the Rutgers School of Dental Medicine, including remote C.O.D.E. sites.

To ensure proper implementation of these guidelines, all faculty, staff and students will be educated about the use of best management practices as they apply to clinical programs of the Rutgers School of Dental Medicine.

Guidelines

1. Use mercury-free material when appropriate
   - The Rutgers School of Dental Medicine utilizes composite and other mercury free restorative materials when indicated as an appropriate restorative material; amalgam is utilized when an alternative material is not considered adequate for the procedure at hand.

2. Eliminate the use of bulk elemental mercury
   - Bulk elemental mercury is not utilized at the New Jersey Dental School only “pre-capsulated alloy” is used.

3. Recycle empty/opened disposable capsules containing amalgam
   - The entire contents of used, broken and unusable amalgam capsules will be collected and stored in airtight containers labeled, “Non-contact Amalgam Waste for Recycling” and also marked as “Hazardous Waste.”

4. Maintain and operate an amalgam separator in accordance with the manufacturers specifications and complies with ISO 11143
   - Facilities Administration and Materials Management will maintain the installed separator.

5. Install chair-side traps in both the evacuation lines and cuspidors (where applicable) when restoration work is done
   - ReplaxiUm chair-side traps when indicated and plaxiUm them in an airtight container marked, “Contact Amalgam Waste for Recycling” and also marked as “Biohazard” and “Hazardous Waste.”

6. Do not rinse traps or filters in sinks and do not flush amalgam waste down drains
   - Traps, filters and used amalgam waste will be collected and stored in airtight containers marked, “Contact Amalgam Waste for Recycling” and also marked as “Biohazard” and as “Hazardous Waste.”

7. Use only non-bleach, non-chlorine cleaners to clean vacuum system lines
   - Vacuum lines will be cleaned with an enzymatic cleaner.
8. Recycle extracted teeth containing amalgam
   - All extracted teeth will be placed in airtight containers of 70% Isopropryl Alcohol provided/picked-up by Clinical Affairs.
   - After collection, all teeth will undergo further sterilization in 10% Formalin for a minimum of two weeks in accordance with the BMP flow chart.
   - All teeth will be collected, transported, processed, distributed or recycled under the supervision of the Office for Clinical Affairs.
   - Any faculty receiving teeth from Clinical Affairs for educational purposes will be responsible for returning them to Clinical Affairs for proper recycling.

9. Recycle all non-contact amalgam
   - Unused scrap amalgam and capsules are to be placed in airtight containers marked “Non-contact Amalgam Waste for Recycling” and also marked as “Hazardous Waste,” provided/picked-up by Clinical Affairs.

10. Recycle all amalgam waste containers when full
    - Recycling of amalgam waste will be handled by RUTGERS-EOHSS (Environmental, Occupational, Health and Safety Services) through the Office for Clinical Affairs.

11. Recycle of plastic typodont teeth
    - Plastic typodont teeth restored with amalgam in both clinical and pre-clinical exercises may only be disposed of in containers marked “Non-contact Amalgam Waste for Recycling” and also marked as “Hazardous Waste.” If a student wishes to keep their project teeth, then these teeth can only be disposed of in accordance with the SDM BMP protocol.

12. Extramural Sites
    - All extramural sites that contact EOHSS directly for a pick-up of amalgam waste must keep a log of the pick-up date and content of items removed.

13. EOHSS must pick up all accumulation containers of amalgam waste at least once per year.

14. Five-gallon contact and non-contact amalgam waste containers will be placed in the general area where the waste is being generated.
Glossary

**contact amalgam:** Amalgam that has been in the patient’s mouth. This includes extracted teeth with amalgam and chair-side traps.

**non-contact amalgam:** Excess amalgam leftover at the end of a procedure that was not utilized including the spent amalgam capsule.

**Chair-side traps:** A filter device at cuspidor and evacuation end to capture amalgam waste.

**pre-capsulated alloy:** A pre-dosed capsule of silver alloy and mercury.

### Materials Distributed

<table>
<thead>
<tr>
<th>Department</th>
<th>Extracted Tooth Containers</th>
<th>Non-contact Amalgam Containers</th>
</tr>
</thead>
<tbody>
<tr>
<td>PG Prosthodontics</td>
<td>1</td>
<td>20</td>
</tr>
<tr>
<td>PG Periodontics</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Special Care Tx Ctr</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>PG Endodontics</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Oral Medicine</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Emergency</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Faculty Practice</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Extramural/CODE (combined)</td>
<td>3</td>
<td>30</td>
</tr>
<tr>
<td>Orthodontics</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pre-Clinic</td>
<td>0</td>
<td>10</td>
</tr>
</tbody>
</table>

Please note that where a single container is distributed, it is intended for the entire department’s use. This single container distribution is based on the specific department’s indication that they are not amalgam users and/or they do not perform extractions. Each department will have at least one container in anticipation for extenuating circumstances.

Where more than one container is distributed, they are to be placed in each operatory unit. Additionally, every undergraduate unit will have one container marked “Non-contact Amalgam Waste for Recycling” and also marked as “Hazardous Waste.”

Hepa-filter bags located in each unit in the pre-clinic laboratory will be replaced and recycled at least yearly. The filters, which may contain amalgam scrap, will be placed in non-contact amalgam containers.
Best Management Practices (BMP) Flow Chart

Extracted teeth from SDM Departments D.O.C. and CODE sites

STORED IN 70% ISOPROPYL ALCOHOL

PERIODIC PICK-UP AND TRANSPORT BY CLINICAL AFFAIRS TO SDM DESIGNATED FACILITY

Restored teeth plaxiUmd in 10% Formalin until needed (Minimum 2 weeks)

Unrestored teeth plaxiUmd

5.25% NaOCl (min. 2 weeks)

Unrestored teeth are autoclaved

Autoclaved teeth plaxiUmd
In Glycerin/Hydrogen Peroxide 50/50 solution for re-hydration until needed

rev 5-11-10
Dental Materials Protocol - Predoctoral

Any dental material that is not provided by the New Jersey School is not permitted under any circumstance to be utilized for patient care by students, faculty, patients and any other personnel in any of the Dental Schools Clinics.

Drug Dispensing Protocol - Predoctoral

Anesthetic:

- All predoctoral students may request **one 1.8cc. cartridge of local anesthetic** and **one long or short needle** from the dispensary as they are requesting instrumentation to set up their assigned unit prior to seating their patient.

- No anesthetic shall be administrated without receiving a “start for treatment” (verbal authorization) from the attending faculty.

- If required, additional cartridge(s) may be requested but only with the prior written authorization from the attending faculty. Request for additional anesthesia forms are available at each dispensary.

Antibiotics:

- Antibiotics for prophylactic may be dispensed one hour prior to treatment of the patient.

- A written request for the dispensing of the specific antibiotic should be pluxUmd in the consultation page of the patients record and signed by the attending faculty.

- The Department of Oral and Maxillofacial Surgery may dispense this medication based on availability and at their discretion.

Pain Medications:

- A written request for the dispensing of specific pain medications (Tylenol, Ibuprofen, Aspirin) should be pluxUmd in the consultation page of the patients record and signed by the attending faculty.

- The Department of Oral and Maxillofacial Surgery may dispense these medications based on availability and at their discretion.

- All requests for controlled substances must be written on a New Jersey State Prescription form and given to the patient. RUTGERS-SDM does not dispense controlled substances.

Any drug or anesthetic that is not provided by the New Jersey School is not permitted under any circumstance to be administered by students, faculty, patients and any other personnel in any of the Dental School’s Clinics.
Lab Dispensary
The commercial lab dispensary is located in Room D-764 and is open from 9:00 a.m. to 4:45 p.m. All prosthodontic and precious metal cases must have a financial counselor's authorization to receive clearance for processing or issuing of metal.

Students are not permitted to send cases to the commercial laboratories without authorization of the Equipment Control Clerk. This person follows the protocol established by the Department of Restorative Dentistry and acts as liaison to the commercial laboratory by preparing cases for shipment, receiving them upon completion, and issuing the processed cases to the students. The commercial laboratory invoices are checked and processed for payment by this person.

Student Laboratories
Student laboratories are provided for student use to facilitate in all aspects of their laboratory work associated with patient treatment. These laboratories are to be cleaned and maintained after each student use. All equipment is to be treated in a manner consistent with maintaining the longevity of its operation. Any student found not to be in adherence with the above would be banned from using the lab. If a particular student cannot be identified as responsible for the lab being left in an unclean or dysfunctional state, the laboratory will be closed to all students.
CHEMICAL SPILLS should be reported in the following manner:

PROCEDURES FOR A SMALL SPILL  
(≤ 4 oz liquid/solid)  
► Call 2-6679, SDM Environmental Safety in the Office for Clinical Affairs  
- Give your name and location of the spill  
- Give the name of the chemical  
- Give approximate amount of spill  
- Give a phone number where you can be reached for further information  
- Report whether any injuries were sustained  

Trained staff will do the following in the event of a SMALL Spill:

- **Assess** whether you are able to clean up the spill, based on experience and training, as well as the availability of hazard information and spill response equipment / supplies available.
- Alert those in the immediate area.
- Isolate the area to prevent the contamination from spreading.
- Turn off all ignition sources if spilled material is flammable.
- **Review** the Material Safety Data Sheet (MSDS) for the spilled material.
- Wear appropriate personal protective equipment.
- **Use** the appropriate spill cleanup kit.
- **Apply** absorbent or pad to the spill.
- Collect the residue and plaxiUm it in a yellow Hazardous Material Bag; plaxiUm yellow waste bag in Lab C-866 to be picked up by EOHSS.

PROCEDURES FOR A LARGE SPILL  
(≥ 4 oz liquid/solid)  
► Call 2-6679, SDM Environmental Safety in the Office for Clinical Affairs  
- Give your name and location of the spill  
- Give the name of the chemical  
- Give approximate amount of spill  
- Give a phone number where you can be reached for further information  
- Report whether any injuries were sustained
Trained staff will do the following in the event of a LARGE Spill:

► SDM Environmental Safety in the Office for Clinical Affairs will call Public Safety Dispatch (PSD) at extension 2-4490 if spill is too large for Staff to cleanup.

► PSD will contact EOHSS at 2-4812 and dispatch an officer to the scene, if necessary.

■ Evacuate the immediate area to prevent exposure.

■ Isolate the area to prevent the contamination from spreading.

Notify the administrator, manager or supervisor of the area.

EOHSS will do the following when responding to a spill

■ Call the person reporting the spill.

■ Dispatch the on-call emergency responders to the spill area.

■ Assess the situation and determine if the cleanup can be done internally.

■ EOHSS will do the cleanup, if they are capable.
  If Newark HAZMAT is needed, EOHSS will have PSD notify them.

■ If the University’s spill contractor is needed, EOHSS will contact them and oversee the cleanup.

SDM Environmental Safety, Office for Clinical Affairs will do the following AFTER the Incident.

■ Restock spill kits; report discharged fire extinguishers to the area supervisor for recharging.

■ Contact Housekeeping at extension 2-6180 to have the cleaned spill area wet mopped.

■ Report all work-related accidents, injuries or illnesses to the Office of Risk and Claims Management.
EMERGENCY DENTAL CARE PROTOCOL AT RUTGERS SCHOOL OF DENTAL MEDICINE

Patient in pain or discomfort should be first triaged for this situation prior to any other treatment.

I. A patient assigned to a student, who presents for regular care and informs the student that they are experiencing discomfort or pain:
   • The student immediately informs the GPA that their patient presented with pain.
   • The GPA will triage the patient and make the necessary referral.
   • The student will immediately contact the specified specialty and ensure the patient is treated.
   • The student will immediately report to the GPA, any deviation in the GPA’s initial triage referral.

II. A patient not assigned to a student but is treatment planned.
   • These patients report to the Front Desk and are referred to their designated Group Receptionist.
   • The Receptionist requests the patient’s dental record and then contacts the DCC.
   • The DCC immediately assigns the first available student to the case.
   • The student immediately informs the GPA that a patient presented with pain.
   • The GPA will triage the patient and make the necessary referral.
   • The student will immediately contact the specified specialty and ensure the patient is treated.
   • The student will immediately report to the GPA, any deviation from the GPA’s initial triage referral.

III. The following patients will be referred to the regular Emergency Clinic, to be treated by students assigned to this rotation, under the supervision of the Diagnostic Sciences faculty.
   • A new not previously registered patient.
• A patient previously assigned to a group but not treated within the last year (to determine eligibility, please review patient’s dental record).

• A patient that presents for screening and it is determined that the patient is having discomfort.

• A patient not treatment planned.

• A registered patient, designated as “Endo Only.”

• A patient previously seen in Emergency Clinic but not assigned to a student.

IV. OTHER

• Patient with Post OP Pain who completed Endodontic therapy – unassigned to a student will be seen by the group where treatment performed.

• Patient of record from either the Oral Medicine Clinic or the Special Care Clinic, who has been treated during the last two years, should be referred to their own clinic for resolution of the patient’s problem. If a patient of these clinics has not been treated within the last two years, this patient will be referred to the regular Emergency Clinic in the Dental School.

• Patient referred to the Endodontic Post Graduate Area from an Undergraduate student should be referred back to the assigned Post Graduate treating doctor.

• Post OP Complications of Post Graduate Root Canal therapy should be referred to that clinic for resolution of the patient’s problem.

• The Associate Dean for the Office of Clinical Affairs has the final decision on the location in which an emergency patient will be seen, based on the availability of clinic space and a student provider or any other special circumstances in both the Undergraduate Clinic and the Emergency Clinic.
Emergency Care for Dental Patients After Hours or on Weekends

When a patient calls for Emergency Care Services after school hours or during the weekend or holiday, the patient receives the following message:

“Emergency care at the school is offered on Monday at 2 pm most days, and Tuesday through Friday, at 8:00 am and 12:00 pm on a first-come, first-served basis. There is an initial fee of $85.00 for the emergency exam and x-ray only. Depending on treatment needed, there is an additional charge that must be paid before treatment begins.

• If you are calling after school hours or during the weekend or holiday, and you are a registered patient, please call (973) 972-0003 for emergency services.

• If you are not a patient of the Dental School, dental emergency care may be obtained at the University Hospital Emergency Room. All patients who seek care at University Hospital will be responsible for any hospital charges incurred. For additional emergency care at University Hospital, please call (973)-972-5123.”

FINANCIAL RESPONSIBILITIES - PATIENT CARE

Clinic income is a vital component in the overall operating budget of SDM. The dental student must be actively involved in overseeing payment for treatment.

Protocol

1. Patients are placed on a payment plan that is based on the treatment plan developed by the undergraduate student and the treatment faculty.
   • Any patient who is being treated in the undergraduate clinic and who is referred to a closed clinic (such as oral surgery) or to a postgraduate program for treatment remains on the payment plan.
   • Where Medicaid is accepted, a department must accept Medicaid fees for procedures.

2. Payment plans are developed by the DCC using the School’s Fee Schedule.
   • A payment plan is developed by dividing the total fee for treatment by the number of estimated visits to establish payment due at each visit.
   • The student, patient, and attending faculty sign the treatment plan.
   • At no time should the number of payments exceed the number of anticipated visits for completion of the treatment plan.
   • The patient’s payment plan will be included in the dental record and an executed copy given to the patient.
• The fee for the Implant Fixture, Code D0610, must be pre-paid before implant is ordered. Abutment and crown can be incorporated into payment plan.
• A Dental Comprehensive Care Coordinator or Financial Counselor should review payment plan and treatment prior to any insertion of prosthetic. This ensures that no addendums have been added to existing treatment plan or deletions that may affect the patient's payment plan and/or the total amount owed by the patient.

3. Changes in the treatment plan will require a new payment plan and the deletion of the old payment plan.
• A dated and signed entry must be made on the treatment plan in the dental record indicating any changes.
• To ensure compliance, any additions or deletions to the PEF must be co-signed by the GPA.

4. Patients who express difficulty with payments should be referred to a financial counselor or DCC, who will then meet with the Assistant Dean to resolve this issue.

5. If scheduled payment is not received, the student can treat the patient, but must inform the patient that a double payment is due at the next visit.
• On the second visit, the student will ask the patient for payment prior to the treatment. If the patient is not prepared to pay, the student will contact the DCC to discuss the patient's financial responsibility. If payment is not received at the next visit, the patient will be treated at this visit, but no insertion of prosthetics will be made.
• Prior to the third visit, a letter could be sent to the patient confirming the financial discussion of the previous visit.
• On the third visit, if the patient is not prepared to pay prior to the treatment, the patient will be referred to the GPA and the patient informed that active treatment is stopped, but emergency care will still be available.

6. The patient has the option to pay fee-for-service and not have a payment plan. All prosthetic cases must be paid in full before final insertion. Fee-for-service arrangements on prosthetic cases where a laboratory fee will be generated, the patient will agree to pay one-third (1/3) of the fee before the work is started; one-third (1/3) of the fee before the work is sent to the laboratory, and the balance of the fee paid before the work is inserted.

7. Each patient, regardless of his/her economic situation, is required to pay the screening fee.
• Patients with third party coverage must pay the school first. His/her insurance carrier will reimburse the patient.
• A Financial Counselor completes all necessary insurance forms provided by the patient and sends completed form to the patient for submission to insurance carrier.
8. Financial counselors are located at 110 Bergen Street, Room D-718, extension 2-5303, and at Fifty 12th Avenue Oral Health Pavilion, Room D-954, extension 2-4788.

9. Patients whose checks are returned for insufficient funds will have a notation entered in the patient’s dental record indicating that the patient must see a Financial Counselor before treatment begins.

10. If a patient is on Medicaid / Medicaid-HMO, all treatment must be pre-authorized before treatment can begin. The Financial Office will notify the student whether treatment has been approved or denied.

11. All Medicaid / Medicaid-HMO patient records must be given to a Financial Counselor every month for proper billing and eligibility checks.

12. All Essex County grant patients and special program patients must be brought to a Financial Counselor prior to treatment to establish eligibility.

13. Students’ immediate family: Please refer to the Student/Family/Faculty/Staff Fee Policy.

All students are expected to be aware of their patient’s payment status. Students are to stop treatment and consult with their GPA or DCC if their patient’s account status:

1. has a balance equal to or greater than $100.00, and/or
2. has missed two consecutive payment plan payments, and/or
3. has an expired dental Medicaid eligibility.

14. Students are not allowed to pay for their patient’s treatment.

Note: Pre-doctoral Students are responsible for the collection of fees for treatment rendered.
GROUP MEETINGS

The Comprehensive Patient Care System (CPCS) provides time for the development of higher orders of learning, professional life development, and the development of students’ interpersonal communication skills.

The students from each group meet with their GPA and DCC once every four weeks, on Monday from 1:00 p.m. until 2:00 p.m. Attendance is mandatory for all students. An agenda is prepared prior to the meeting by the GPA with input from the Student Group Leader.

GROUP PRACTICE MEETINGS

- **Monthly Group Practice Meetings**
  Third-year and fourth-year students participate in monthly group meetings and “huddle” sessions. These integrative sessions tie together the many diverse experiences encountered by group participants by providing a structured forum for their discussion.

- **Student Progress Meetings**
  On a regular basis the GPA and DCC meet with each student in the group practice regarding the student’s progress in open clinic.

- **Weekly Student Progress Meetings**
  If a student becomes deficient in his/her open clinic requirements it is necessary for him/her to meet on a weekly basis with the GPA. Once the student’s performance is of a satisfactory level these weekly monitoring sessions are no longer necessary.
Verbal Language Interpreting Protocol

Purpose:

This policy is the protocol for the Rutgers School of Dental Medicine to provide interpretive verbal language services for the effective communication when patients or their parents or legal guardians are not proficient in the English language to communicate effectively with faculty, staff and students.

Services:

The Rutgers School of Dental Medicine has contracted with DT Interpreting to provide verbal language interpretation for a wide variety of foreign languages.

The following departments in the dental school have Purchase Orders (PO’s) with DT Interpreting, and each has its own, secure access code:

Post-graduate Prosthodontics
Post-graduate Periodontics
Post-graduate Endodontics
Post-graduate Orthodontics
Pediatric Dentistry
Oral Surgery
Special Care Treatment Center
Diagnostic Sciences
Clinical Affairs

(note: Clinical Affairs covers all undergraduate clinics, including the patient intake center and Emergency registration. Diagnostic Sciences covers Emergency Clinic, Radiology Clinic and Oro-facial pain).

Process:

Any faculty, staff or student who encounters a situation where they are not able to effectively communicate with a patient, their parent or legal guardian due to an inability by either party to understand the language spoken by the other, should immediately report to their assigned department for an access code and copy of the dial-in instructions. Each department will be billed via the access code for this service. Therefore it is the department’s responsibility to maintain access code security.

The patient should be brought to the nearest wall phone, dial 1(866) 237-0174 and follow the instructions as listed. At the provider/staff person/ student’s discretion,
a personal cell phone may be used, but minutes will not be reimbursed by the school.

To prevent potential abuse of this service, DT Interpreting will limit all Rutgers School of Dental Medicine access codes to the following hours of operation:
Monday – Friday
8:00 – 5:00
There will be no access on weekends and major holidays.

Your Dental Treatment notes should always reflect if an interpreter was utilized.
HEARING IMPAIRED PATIENTS PROTOCOL

This policy is the protocol for the Rutgers School of Dental Medicine to provide Interpretative Services and/or auxiliary aids for the effective communication with a deaf and/or hard of hearing patient in accordance with the Americans with Disabilities Act (ADA).

Services and auxiliary aids:

The University of Medicine and Dentistry has contracted with a number of Certified Sign Language Interpreters who are approved New Jersey State vendors. (See List of Approved Interpreters) The Office for Clinical Affairs has also opened and maintains an active “Purchase Order” with an approved vendor for reimbursing said interpreters.

The Office for Clinical Affairs has purchased a Video Interpreting System called the “Deaf-Talk Machine” and maintains a service contract with the Deaf-Talk Company. Instructions for using this machine are attached to the unit. The unit is available on a first come first served basis. The Video Interpreting System may be plaxiUmd on reserve in advance in the Office for Clinical Affairs.

Process for scheduling a sign Language Interpreter:

It is mandated by the Americans with Disabilities Act (ADA), that the school provides the Deaf or Hard of Hearing patient a sign language interpreter, or if the patient consents, the use of a Video Interpreting System. This is accomplished by filling out a “Sign Language Interpreter Request Form” and having the patient sign this form and return it to Clinical Affairs (Rm. D-990). This form must be filled out five (5) business days in advance, so that the Office for Clinical Affairs can schedule an Interpreter. The Office for Clinical Affairs may be able to schedule a sign language interpreter with less than five business days’ notice based on interpreter availability.

For Immediate translation service:

In the event that a deaf or hard of hearing patient presents as an emergency, or without five business days’ notice, the Video Interpreting System, the “Deaf-Talk Machine” may be utilized, but only after the deaf or hard of hearing patient has signed the Video Interpreting System section of the “Sign Language Interpreter Request form”.

In the event of an emergency situation where the Video Interpreting System, the “Deaf-Talk Machine” is unavailable or out of service, the Faculty may use whatever means necessary to communicate with the patient, including but not limited to written notes, drawings, charts, diagrams, non-verbal gestures, lip reading and sign language by staff, faculty or others until a qualified interpreter arrives on site.
Your Dental Treatment notes should always reflect the type of interpreter service utilized. In the event written notes are utilized, they should be dated and kept as a permanent part of the dental record.

The Office for Clinical Affairs will IDT each department for their shared usage of these services.

HYGIENE CLINICAL PROGRAM

Protocol for the Assignment of Patients to the Hygiene Students

Dental hygiene patients are derived from three sources:

I. Active patients
II. Recare patients
III. Hygiene students’ friends and families

I. Active patients
- Are recognized in the AXIUM computer system as “CA” (Clinically Active).
- Are overdue for either a three or six-month periodontal maintenance or prophylaxis appointment.

A. Procedure:
1. Use the AXIUM computer system to generate a report called the “Active Patient Report” designed to include only “recare” patients.
   - The Active Patient Report for recare patients contains the CA patients who are overdue for a periodontal maintenance or prophylaxis appointment.
   - This report can distinguish active patients by student group (A, B, C, D) and/or by student.
2. Add a flag to the Patient Encounter Form (PEF).
   - As the PEF is generated utilizing AXIUM, the clinical computer system recognizes the patient as a clinically active patient as well as a patient overdue for either a periodontal maintenance or prophylaxis appointment and “Flags” the PEF.
   - The “FLAG” should be in a larger font (3x normal), in bold, and is located in the forefront of the PEF for easy identification.
   - Students and faculty should now be able to easily identify their patients who require a periodontal maintenance or prophylaxis appointment and schedule it with a hygienist assigned to the group.
3. Have AXIUM default for Periodontal Maintenance or Prophylaxis
   - Six (6) months following a prophylaxis for a prevention case;
   - Three (3) months following a periodontal phase one reevaluation;
   - Three (3) months following a periodontal maintenance visit.
II. Recare Patients

- Are recognized in the AXIUM computer system as “CR”, Clinical Recare.
- Are due or overdue for either a three or six-month periodontal maintenance or prophylaxis appointment.

A. Procedure

- The DCC retrieves Recare Reports from the AXIUM computer system on a monthly basis.
- The DCC calls or sends a recare letter to the patient to inform the patient of the recare fee, appointment date and time.

1. The DCC schedules the recare appointment with a hygiene student.

   - The hygiene student first records vital signs and reviews the medical history.
   - The hygiene student must request a “start” for each patient prior to treatment from the GPA or any faculty member assigned to the group.
   - The GPA or any dentist on the floor performs a recare exam and orders radiographs, if applicable.
   - The hygiene student takes all necessary radiographs and completes the full data collection. The GPA or any faculty member assigned to the group will develop a recare treatment plan. The hygiene student will perform the prophylaxis or periodontal maintenance visit as indicated by the GPA or faculty member under the supervision of the dental hygiene faculty member.
   - At the completion of the first session, the hygiene student will take the patient and the dental record to the DCC for assignment to a student or to be placed on recare.
   - At the point that no further treatment is indicated, the GPA or assigned faculty will sign the “case complete” and set the recare interval.

2. Hygiene student responsibilities

   - It is the hygiene student’s responsibility to ensure the patient is seen by the GPA and/or the DCC at the completion of the prophylaxis or periodontal maintenance so that continuity of care continues.
   - It is the hygiene student’s responsibility to ensure all fees are collected.
III. Hygiene Students’ Family and Friends

Patients who are not currently patients at the Rutgers School of Dental Medicine and are a friend or family member of the hygiene student are considered new patients and must have a RUTGERS-SDM dental record prior to treatment.

A. The two types of friends and family hygiene patients are

- Hygiene only;
- Patients who wish to continue their dental treatment here at SDM.

1. Hygiene only patients must have a consultation in their dental record by the GPA or other faculty member on the floor clearing the patient for “hygiene only” prior to the start of treatment.
   - Normal and customary fees will apply unless the patient is an immediate family member (husband, wife, or child; not a parent).

2. Patients who wish to continue their dental treatment here at SDM must have a consultation in their dental record by the GPA or other faculty member on the floor clearing the patient for hygiene prior to the start of treatment.

Responsibilities of Hygiene Students

1. It is the hygiene student’s responsibility to ensure the patient is seen by the GPA or faculty person at the completion of the prophylaxis.

2. It is the hygiene student’s responsibility to ensure all fees are collected.
MEDICAL EMERGENCY REVIEW PROTOCOL

- A faculty member is identified by each department to be the coordinator of medical emergency reviews.
- The medical emergency coordinator from each department will be in-serviced about the medical emergency review by the Director of Pre-doctoral surgery if necessary.
- The medical emergency coordinator will run 2 reviews per year within their department with all faculty, staff and Post-Doctoral students if applicable.
- An attendance form will be filled out and kept in each department along with a copy sent to Clinical Affairs.
- Clinical Affairs will oversee the process to assure reviews are being completed and provide the review schedule.
- The Director of Pre-Doctoral Surgery, along with the Oral & Maxillofacial Surgery Nurse, will be available to calibrate the medical emergency coordinator yearly.

MEDICAL EMERGENCY REVIEW SCHEDULE

<table>
<thead>
<tr>
<th></th>
<th>1st Drill</th>
<th>2nd Drill</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Pediatric Dentistry</td>
<td>September</td>
<td>March</td>
</tr>
<tr>
<td>(2) Oral Surgery</td>
<td>September</td>
<td>March</td>
</tr>
<tr>
<td>(3) Endodontics</td>
<td>September</td>
<td>March</td>
</tr>
<tr>
<td>(4) Restorative</td>
<td>September</td>
<td>March</td>
</tr>
<tr>
<td>(5) Periodontics</td>
<td>September</td>
<td>March</td>
</tr>
<tr>
<td>(6) Orthodontics</td>
<td>September</td>
<td>March</td>
</tr>
<tr>
<td>(7) Oral Medicine</td>
<td>September</td>
<td>March</td>
</tr>
<tr>
<td>(8) Pre-Doctoral</td>
<td>September</td>
<td>March</td>
</tr>
<tr>
<td>(9) C.O.D.E.</td>
<td>September</td>
<td>March</td>
</tr>
</tbody>
</table>
NEEDLE STICK (PERCUTANEOUS INJURY) PROTOCOL

- When a percutaneous injury occurs, the operator should wash the affected area and inform his Group Practice Administrator or area supervisor. Persons involved in a percutaneous injury should report immediately to the Office for Clinical Affairs and see the Assistant Dean so that the protocol may be initiated. In his/her absence, a Group Practice Administrator will be notified and will run the protocol.

- Another student or the faculty should stabilize the source patient. After the source patient’s immediate dental needs are met, the source patient is to be brought to the Office for Clinical Affairs to see the Assistant Dean so that the protocol may be initiated. In his/her absence, a Group Practice Administrator will be notified and will run the protocol.

I. During daytime hours (9-5):

Pre-doctoral dental students and/or non-paid post graduate students
- Student completes an Incident Report – Keep the white copy for Clinical Affairs.
- Sends the pre-doctoral dental student and/or non-paid postgraduate student to the Department of Student Health and Wellness Center in the Doctors Office Center, 90 Bergen Street, 1st Floor, Suite 1750 (2-8219) with a copy of the Incident Report.

Faculty/staff/paid PG students-
- Have the faculty/staff/paid PG student fill out an Incident Report – n Keep the white copy for Clinical Affairs.
- Report to Occupational Medicine at the SSB Building, GA Level, Room 167, (2-2900), with the Incident Report.
- The faculty/staff/paid PG student report to Risk and Claims at Interim Building 13, Room 1314, with an incident report, and fill out additional paperwork.

Source Patient

1- The source patient is then asked to read, initial, and sign the patient authorization form for HIV testing, available in English or Spanish. (Keep this form.) Print patient’s name and date of birth at top right corner of the authorization form and serology request form.

2- The Assistant Dean or the GPA writes an administrative note on the consult page of the patient’s dental record indicating that a percutaneous injury has occurred and if the patient agreed to serology testing.

3- If the patient agrees to serology testing, the Assistant Dean or the GPA stays with the patient until arrangements can be made to escort the patient to the Serology Lab in Room C-456 at University Hospital. Ext. 2-4087.
4- During this time, the patient is counseled by the Assistant Dean or GPA about:
   - Testing and reason for it.
   - Results and what it means to the source patient and the involved faculty/staff/student member.
   - Results given to the patient for HIV and additional counseling, if necessary.

5- The Assistant Dean or GPA refers the patient directly to Serology at University Hospital, Room C-456 with the filled out “Request for Chemistry, Hematology, and Serology Tests on Blood/Plasma/Serum” form, and request the following tests:
   - Hepatitis B SurfaxiUm Antigen (R) - HBSAG
   - Hepatitis C Antibody – HC
   - HIV Antibody (R) – HIV

   The patient receives a Medical ID number, which should be returned to the Assistant Dean who will use this information to get the patient’s serology results and to pay for services.

6- If the patient declines serology testing, the patient may be discharged.

7- After 2-3 days, the Assistant Dean calls the Director of the Office of Laboratory Medicine, Rm. C-118 at 2-4086, or the Accession Area at 2-4080 for results, or Student Health (2-8219) to get the results.

If a Positive Result:

A. The Assistant Dean or GPA will call Department of Student Health in the Doctors Office Center (2-8219) and tell them of this positive result so that they may better counsel the student.

B. The Assistant Dean refers the patient to their own physician or to the Infectious Disease Clinic to make an appointment at the Ambulatory Care Center, 140 Bergen Street, D-Level, (2-8320) where additional counseling is provided.

If a Negative Result:

A. The Assistant Dean or GPA will call Student Health in the Doctors Office Center (2-8219) and tell them of this negative result so that they may better counsel the student.

B. The Assistant Dean or GPA calls the patient with negative results (speaks only to the patient).
II. After school hours:

All students/staff/faculty:
- Have the student/staff/faculty fill out an Incident Report – Keep the white copy for Clinical Affairs.
- Refer all students/staff/faculty to the University Hospital Emergency Room triage nurse, who will refer the patient to Fast Track.
- The Assistant Dean or Group Practice Administrator will call the source patient on the next available clinic session to discuss with them what happened and to bring the patient in for testing if the patient agrees to being tested.

Source Patient:
If the patient agrees to serology testing, the Assistant Dean or GPA refers the patient directly to Serology at University Hospital, Room C-456 for testing using the same serology paperwork.

- After 2-3 days, the Assistant Dean calls the Director of the Office of Laboratory Medicine, Rm. C-118 at 2-4086 for results.
- Calls patient with negative results (speaks only to the patient).
- Have patient brought back to the Assistant Dean’ office if results are positive for further counseling and directs patient to either their own physician or Infectious Disease Clinic to make an appointment at the Ambulatory Care Center, 140 Bergen Street, D-Level, (2-8320).

III. Financial

- The Assistant Dean e-mails Ms. Marcia Mack (Mackma) at (University Hospital Patient Accounts Outpatient Services) about a week later to request a bill using Medicare fees for serology testing.
- The Assistant Dean submits a request for payment memo along with a copy of the incident report and the bill to Mr. Arthur Moore in Room D –740 of the Dental School, Extension 2-0266 for resolution of the bill.
- The Assistant Dean makes an entry in the consult page of the patient’s record that the patient was informed of the results and the bill was paid and inserts copies of the results sealed in a plain white envelope marked CONFIDENTIAL in patient’s dental record (pocket of chart). A copy of the results should be also given to the patient.
PATIENT ADVOCACY

**Associate Dean for Clinical Affairs**

The Associate Dean for Clinical Affairs has the final responsibility for bringing quality, affordable oral health care to patients of the Rutgers School of Dental Medicine. The Associate Dean provides an interface between the Rutgers School of Dental Medicine and national consumer organizations to ensure the school's involvement in developing oral health programs.

**Assistant Dean for Clinical Affairs**

The Assistant Dean acts as the patient’s ombudsman and attempts to resolve patient complaints from the pre-doctoral and post-doctoral clinics via consultation with the chairpersons of the various departments when appropriate and confers with the legal department when necessary.

- Reduces barriers to use of clinic by providing information and counseling services to patients seeking treatment or in treatment.
- Provides patients for assignment to special clinics such as dental hygiene, continuing education and postgraduate programs.
- Coordinates all percutaneous injury incidents occurring in the clinics with the Office of Risk and Claims, Office for Legal Management and other appropriate University Departments.
- Maintains a log of patient complaints and their outcomes.

**Group Practice Administrator (GPA)**

The GPA monitors the student’s comprehensive care patients on a regular basis. On these scheduled reviews, the GPA discusses the management of these patients in terms of:

- timing sequence of treatment
- patient’s financial status
- student/faculty coverage.

With this information the Group Practice Administrator can better make a determination of the patient’s treatment and the patient’s well-being here at the Rutgers School of Dental Medicine.

**Dental Care Coordinator (DCC)**

Upon assignment to a predoctoral student, each patient is given the name and telephone number of the DCC assigned to the student's group practice.

Using current information from the computerized data system and the patient records, the coordinator monitors treatment to facilitate timeliness and continuity of care. The DCCs are also available to counsel patients about appointment and financial responsibilities and to assist those in need of special services, including transportation and emergency care. The patient is seen by the DCC at completion or termination of treatment for an exit interview to evaluate the patient’s response to the clinical program.
COMPREHENSIVE PATIENT CARE SYSTEM (CPCS)

At the SDM, there is a Comprehensive Patient Care System, a group of functionally interrelated resources comprised of faculty, staff, students, patients, facilities, and other components organized to meet patients' total oral health care needs. The SDM CPCS requires that providers of health care maintain a continuous, caring and ethical relationship with patients at all levels of care rendered.

Goals and Objectives
The SDM CPCS is based on a patient-centered, prevention-oriented clinical care philosophy. It is intended to 1) maintain a responsive and sensitive educational environment characterized by positive interpersonal relationships among faculty, patients, students and staff; 2) encourage the delivery of care consistent with the highest standards that bridge all clinical disciplines; 3) provide a setting in which faculty with discipline expertise can interact in formulating a diagnosis, developing treatment plans, delivering treatment, and maintaining patients' health; and 4) strive to integrate the didactic instruction in social, ethical and humanitarian components with the delivery of patient care. The goals of the CPCS, which focus on patient care, education, environment and assessment, are implemented through the Group Practice Model.

Group Practice Model
The Group Practice Model is structured to facilitate the interaction of patients with students, faculty and staff and is accomplished using a model that simulates a group private practice.

Objectives of the Group Practice Model
The objectives of the Group Practice Model are:

1. To encourage interdisciplinary cooperation through faculty from all disciplines working together to facilitate student learning and patient care;

2. To enhance the ability of students to provide interdisciplinary care;

3. To enhance student opportunity to provide multiple procedure treatment to patients in the same clinic session;

4. To provide faculty and students with the computer resources and necessary training to manage patient care activities;

5. To accomplish treatment planning with specialty faculty as a resource and, in many instances, with the faculty who will be supervising the care;

6. To monitor student attendance in the open clinic;

7. To monitor student progress on clinical cases;

8. To enhance the ability of faculty and administration to insure student compliance with infection control standards;
9. To encourage the collection of fees and provide a system for reviewing the patient’s financial records by students and the Dental Care Coordinator (DCC);

10. To provide the opportunity for increasing clinical income.

CPCS Team
The CPCS is composed of four group practices, each of which functions as a team and consists of:

- A Group Practice Administrator (GPA);
- Clinical faculty representing Periodontics, Fixed Prosthodontics, Endodontics, Removable Prosthodontics, Operative Dentistry, Treatment Planning, and Prevention;
- A Dental Care Coordinator (DCC);
- Receptionist (shared by two group practices);
- Dental Assistants (financial resources will dictate the number assigned to each group).

Each team provides the administrative support for Third-year and Fourth-year dental students assigned to the group practice.

Although the GPA working through assigned clinical faculty is responsible for assuring that patients assigned to the Group Practice receive care, students assigned to the group practice have primary responsibility for providing care to these patients. Quantitative student requirements are not allowed to compromise patient care.

Student Assistance

Group Practice Administrator (GPA)
The GPA monitors student progress on a regular basis to ensure an appropriate mix of patients, clinical progress in completion of patient treatment procedures, and management skills related to delivery of patient care. Personal interviews are scheduled throughout the academic year with every student, the DCC and the GPA. At this meeting there is a review of patient progress, patient treatment, management of cases and student progress. At times the GPA will elect to plaxium the student on a weekly monitoring protocol to assess and monitor student progress.

The GPA interacts with the DCC and students when referrals are necessary to assure continuity of care or when special circumstances dictate referral to other dental health care providers (i.e., the postdoctoral specialty clinics, advanced education in general dentistry or general practice residents).

Dental Care Coordinator (DCC)
A major portion of the DCC’s time is devoted to assisting students achieve a satisfying and productive clinic experience while meeting their clinic responsibilities. The DCC meets regularly with his/her students on an individual basis. The DCC monitors student appointment productivity, reviews adherence to fee and clinic policies, and assists in processing student requests for patient assignment, transfer, referral, recare, and inactivation. The DCC assists the students in the management of their patient appointment schedule through direct communication with patients, when required. The DCC also assists the students in achieving their quality assurance responsibilities.

68
Each student is assigned his/her own unit. The 12th Avenue Oral Health Pavilion and the South Clinic on D-level of the SDM each house two Group Practices.

Each Group Practice utilizes its own dispensary. The number of chairs assigned to a discipline is determined by specified faculty/student ratios. The Groups share a common sterilization center and common dental laboratories.

Because the CPCS attempts to simulate a large associate group practice setting, dental assistants, students and staff are part of the group practice experience. Assigned patient emergency, urgent care and recare are managed by each Group Practice.

Responsibility for Patient Care
Clinical delivery of patient care in the CPCS is the primary responsibility of the student whose name appears on the dental record. Faculty supervises the delivery of care and assures that their departmentally accepted standards of care are met. However, faculty must also function, interdepartmentally with members from the Department of Diagnostic Sciences and the GPAs and DCCs in assuring the overall management of the patient’s treatment needs. This includes timely and sequential delivery of care according to the prescribed signed and dated treatment plan, routine monitoring of changes in the patient’s medical health status and treatment needs, attention to the preventive dentistry aspects of the patient, and ethical and professional characteristics exhibited by members of the group practice (faculty, staff, students).

A student follows the progression of a patient’s case and has the advantage of case re-evaluation as part of a quality assurance protocol. The student provides oral health care in an environment that supports ethical professional standards based upon patient needs, not institutional requirements. Students progress through their Third-year and Fourth-year under the guidance of a GPA, DCC and faculty. The student works within this system to fulfill the treatment needs of all patients assigned to him/her, as well as:

- completing identified procedures considered to be essential to developing clinical skill;
- fulfilling patient care and management assumptions;
- presenting identified cases to the faculty where comprehensive care has been completed;
- calling all assigned patients in an oral health maintenance program.
### Diagnostic Sciences, Radiology and Oral Medicine

<table>
<thead>
<tr>
<th>Estimated Specific Procedure Requirements</th>
<th>Quantity</th>
<th>Estimated Point Value</th>
<th>Total Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment plan 150 Hours (100 Junior year, 50 Senior year)</td>
<td>80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology (Junior year attendance technique &amp; interpretation (2 FMS &amp; 2 Panoramic Competencies)</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nutritional Counseling 10 Hours (Junior/Senior years:2 evaluations, 2 competency)</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Medicine 30 Hours (Completion of rotation requirements)</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>150</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Prevention

<table>
<thead>
<tr>
<th>Specific Procedure Requirements</th>
<th>Quantity</th>
<th>Estimated Point Value</th>
<th>Total Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral hygiene competency exam</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Preventive therapy plan competency</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Chemotherapeutic Competency exam</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Tobacco Counseling</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Oral Hygiene Instructions</td>
<td>12</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Adult Prophylaxis</td>
<td>12</td>
<td>4</td>
<td>48</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Point Category</th>
<th>Minimum Required Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure specific points</td>
<td>67</td>
</tr>
<tr>
<td>Discipline specific points</td>
<td>3</td>
</tr>
</tbody>
</table>

**TOTAL PREVENTION POINTS** 70
### Periodontics

<table>
<thead>
<tr>
<th>Specific Procedure Requirements</th>
<th>Quantity</th>
<th>Estimated Point Value</th>
<th>Total Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phase I Evaluation</td>
<td>5</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>Periodontal Maintenance</td>
<td>8</td>
<td>5</td>
<td>40</td>
</tr>
<tr>
<td>Surgical Assist</td>
<td>12</td>
<td>5</td>
<td>60</td>
</tr>
<tr>
<td>Periodontal Diagnosis</td>
<td>8</td>
<td>5</td>
<td>40</td>
</tr>
<tr>
<td>Perio Diagnosis Competency</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Periodontal Scaling/RP</td>
<td>9</td>
<td>5</td>
<td>45</td>
</tr>
<tr>
<td>Scaling Competency</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Mock Board Participation</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Minimum Required Points**

- Procedure specific points: 210
- Discipline specific points: 50

**TOTAL PERIODONTAL POINTS**: 260

Surgical assists can be for periodontal surgeries or implant surgeries done in periodontics.

### Endodontics

<table>
<thead>
<tr>
<th>Specific Procedure Requirements</th>
<th>Quantity</th>
<th>Estimated Point Value</th>
<th>Total Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Molar – endodontic therapy</td>
<td>1</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Premolar – endodontic therapy</td>
<td>2</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Anterior – endodontic therapy</td>
<td>5</td>
<td>10</td>
<td>50</td>
</tr>
<tr>
<td>Recall</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Caries removal exercise</td>
<td>2</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>Clinical Competency Exam</td>
<td>1</td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

**Total**: 201

**Procedure Specific Points**

<table>
<thead>
<tr>
<th>Procedure Specific Points</th>
<th>Code</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pulpotomy</td>
<td>03220</td>
<td>10</td>
</tr>
<tr>
<td>Bleaching</td>
<td>03960</td>
<td>5</td>
</tr>
<tr>
<td>Surgical assist</td>
<td>30061</td>
<td>5</td>
</tr>
<tr>
<td>Post spaxiUm preparation</td>
<td>D3950</td>
<td>10</td>
</tr>
<tr>
<td>Incomplete endodontic therapy</td>
<td>D3332</td>
<td>10</td>
</tr>
<tr>
<td>Pulp vitality testing</td>
<td>D0460</td>
<td>10</td>
</tr>
</tbody>
</table>
Point Category: Total Required Endodontic Points: 184

The balance may be satisfied with any of the non-required procedures that result in the rewarding of points.

Requirements are eight (8) clinical cases, one (1) of which must be a molar. Therefore, if 7 premolars are treated (140 points) and no anteriors, the total would be 50 points higher (279).

General Dentistry

Specific Procedure Requirements

Junior Year minimum requirements

I. Patient Based Competency Examinations

1) Caries Removal Competency Examination

2) One of following Operative procedure competency examinations:
   - Class V Amalgam or Composite
   - Class IV Composite
   - Class III Composite
   - Class II Composite
   - Class II Amalgam
   - Complex Amalgam

II. Manikin Based Clinical Exams

1) Class III Composite
2) Class II Amalgam

III. DAU Competency

IV. Other
   a. Caries risk assessments on every restorative patient
   b. Six (6) amalgam polishing

V. Minimum Clinic Points in Operative Procedures: 80 (190 points recommended)

Senior Year
I. Patient Based Competency Examinations
   1) All of the following Operative procedures (excluding those examinations performed in the Junior year):
      - Class V Amalgam or Composite
      - Class IV Composite
      - Class III Composite
      - Class II Composite
      - Class II Amalgam
      - Complex Amalgam
      - Class II Amalgam on Patient Mock Board Examination
      - Class III Composite on Patient Mock Board Examination

II. DAU Competency

III Other
   a. Caries risk assessments on every restorative patient
   b. Six (6) amalgam polishing

IV. Minimum Points (Junior and Senior Years Combined) 400

Fixed Prosthodontics

<table>
<thead>
<tr>
<th>Specific Procedure Requirements</th>
<th>Quantity</th>
<th>Estimated Point Value</th>
<th>Total Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cast post and core</td>
<td>3</td>
<td>15</td>
<td>45</td>
</tr>
<tr>
<td>Full cast metal crown</td>
<td>1</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>Porcelain fused to metal crown</td>
<td>5</td>
<td>25</td>
<td>125</td>
</tr>
<tr>
<td>3 unit or greater bridge*</td>
<td>1 (3 units)</td>
<td>55</td>
<td>55</td>
</tr>
<tr>
<td>Any combination of Fixed units**</td>
<td>2</td>
<td>25</td>
<td>50</td>
</tr>
<tr>
<td>All ceramic crowns</td>
<td>5</td>
<td>25</td>
<td>125</td>
</tr>
</tbody>
</table>

(At a minimum students will be required to treatment plan at least 1 fixed implant-supported restoration or refit an existing denture onto 2 stud attachments or 1 bar.) (Minimum of 1 fixed implant retained crown. This requires a surgical template with diagnostic wax-up for an additional 15 non-specific points).

Minimum

<table>
<thead>
<tr>
<th>Point Category</th>
<th>Required Points</th>
</tr>
</thead>
</table>
Fixed Competencies Requirements:

1. **Fixed Partial Denture Competency** – all seniors. Students must have successfully completed two (2) competency simulations by October of the senior year as partial fulfillment of the Departmental requirements for graduation.

   Competency Examination – 3 unit fixed partial denture simulation and ceramic preparation on the manikin. Grading will include teeth preparation.

2. **Combined Fixed and Diagnostic Cast Competency** – all seniors. Students must have successfully completed one competency prior to graduation from the senior year as partial fulfillment of the Departmental requirements for graduation.

   Competency Examination – Mount, verify and evaluate diagnostic casts on an articulator and restore a tooth or teeth with a fixed prosthodontic restoration.

Removable Prosthodontics

<table>
<thead>
<tr>
<th>Specific Procedure Requirements</th>
<th>Quantity</th>
<th>Estimated Point Value</th>
<th>Total Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial denture*</td>
<td>6</td>
<td>40</td>
<td>240</td>
</tr>
<tr>
<td>Complete denture**</td>
<td>6</td>
<td>40</td>
<td>240</td>
</tr>
<tr>
<td>Denture repair***</td>
<td>3</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Transitional partial denture***</td>
<td>2</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Reline (laboratory-hard)***</td>
<td>1</td>
<td>10</td>
<td>10</td>
</tr>
<tr>
<td>Reline (chairside-hard)***</td>
<td>1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Tissue conditioning (experience)</td>
<td>2</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Point Category</th>
<th>Minimum Required Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL REMOVABLE PROSTHODONTIC POINTS</td>
<td>12 units 547</td>
</tr>
<tr>
<td></td>
<td>7 misc procedures***</td>
</tr>
</tbody>
</table>
* The partial denture must be a cast metal framework. At least one of the partial denture units must be a distal extension partial denture.
**A complete denture can be an immediate, overdenture or complete upper or lower denture.
Competencies will be completed on patients assigned to the students during the scheduled treatment regimen, not as added procedures.

REMOVABLE COMPETENCY REQUIREMENTS:

1. Complete Denture Competency – One competency examination must be successfully completed prior to graduation. Examination may be taken after March 1 of junior year and must be completed prior to graduation.

   Competency Examination – The Wax Trial Denture Appointment.
   Student will notify evaluators and schedule the appointment.
   Student will conduct this appointment independently and will notify the evaluators after he/she is confident that all goals of the wax trial denture appointment have been met.

2. Removable Partial Denture Competency – One competency examination must be successfully completed prior to graduation. Examination may be taken after March 1 of junior year and must be completed prior to graduation.

   Competency Examination – 3 part examination
   1. Design of Removable Partial Denture (Part A)
   2. Recontour of all teeth – final impression – master cast (Part B)
   3. Written work authorization, final survey, dentogram (Part C)

3. Tissue Conditioning Competency-One competency examination must be successfully completed prior to graduation.

   Competency Examination – The Tissue Conditioning Appointment. Student will notify evaluators and schedule the appointment. Student will conduct this appointment independently and will notify the evaluators after he/she is confident that all goals of the tissue conditioning appointment have been met.

IMPLANT-SUPPORTED FIXED PROSTHODONTICS
Students will be required to treatment plan at least 1 fixed implant-supported restoration or refit an existing denture onto 2 stud attachments or 1 bar.

<table>
<thead>
<tr>
<th>Specific Procedures</th>
<th>Estimated Quantity</th>
<th>Total Point Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wax-Up</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Radiographic/Surgical Template</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>Porcelain fused to metal crown or All-Ceramic crown</td>
<td>1 20-25</td>
<td></td>
</tr>
<tr>
<td>Pontic</td>
<td>1</td>
<td>15</td>
</tr>
</tbody>
</table>

Point Category | Quantity | Minimum Points |
----------------|----------|----------------|
TOTAL FIXED IMPLANT POINTS | 1 units | 35-40 |

GRADING POLICY FOR JUNIOR YEAR:
Clinical evaluations will be completed on all prosthodontic procedures using the critical error-grading format.

Daily session evaluation will be necessary for all clinical procedures in Fixed Prosthodontics and in Removable Prosthodontics. Evaluation will require faculty evaluation based on a critical error format. Daily procedures will be evaluated and recorded in AxiUm.

Clinical evaluation for each case will be determined by the following scale.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>error free</td>
<td>P</td>
</tr>
<tr>
<td>3</td>
<td>minor errors</td>
<td>P</td>
</tr>
<tr>
<td>2</td>
<td>major errors (no critical errors)</td>
<td>P</td>
</tr>
<tr>
<td>1</td>
<td>critical error</td>
<td>F</td>
</tr>
</tbody>
</table>

The final P/F grade for the course will consider daily grades as well as amount of work completed. However, each student is required to obtain a minimum of 160 clinic points of patient care in Fixed and Removable Prosthodontics combined in order to pass this course. As part of the 160 points the student is required to complete three units of Fixed and Removable Prosthodontics including at least one unit of Fixed and one unit of Removable Prosthodontics. It is the student’s responsibility to regularly check to verify that clinic points have been accurately recorded in the computer records (AxiUm program).

Note that 160 points can be achieved by scheduling two Fixed or Removable Prosthodontics sessions per week for 39 weeks. There are actually 43 weeks of clinic time between July 1, 2013 and June 26, 2014 (excluding Holidays, Winter and Spring breaks). As a result, there are 5 weeks beyond what is necessary to obtain 160 points to allow for “lost time” due to student sickness, weather related school closures, etc.

Students lagging in production in either the Fixed or Removable Prosthodontics components of the course will be notified in April of their Junior year. Arrangements to complete the course will then be made on an individual basis. Students must complete all requirements and pass the competency examinations prior to graduation at the end of the Senior year as outlined above. Note that a minimum of 160 clinical points is necessary to pass this course. **Less than 160 points will result in a final grade of “F”**. If a student has less than 160 clinical points, her/his performance will be evaluated by a committee consisting of the course director, the department chairman, the student’s group practice administrator, and the associate dean for Clinical Affairs to determine the student’s eligibility for an “I” (Incomplete) grade. The “I” grade must be removed prior to the student being promoted to the Senior year.

If a student receives a failing grade in the course, remediation or repetition of the course may be necessary according to the “Academic Guidelines” stated in the online Student Handbook.

**GRADING POLICY FOR SENIOR YEAR:**
Grades will be assigned using the SDM scale below:

<table>
<thead>
<tr>
<th>Letter Grade</th>
<th>Description</th>
<th>Grade Points</th>
<th>Exam Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Excellent</td>
<td>4.00</td>
<td>90-100</td>
</tr>
<tr>
<td>B+</td>
<td></td>
<td>3.5</td>
<td>85-89</td>
</tr>
<tr>
<td>B</td>
<td>Average</td>
<td>3.00</td>
<td>80-84</td>
</tr>
<tr>
<td>C+</td>
<td>Fair</td>
<td>2.50</td>
<td>75-79</td>
</tr>
<tr>
<td>C</td>
<td>Unacceptable</td>
<td>2.00</td>
<td>70-74</td>
</tr>
<tr>
<td>D</td>
<td>Failure</td>
<td>1.00</td>
<td>65-69</td>
</tr>
<tr>
<td>F</td>
<td></td>
<td>0.00</td>
<td>60-64</td>
</tr>
<tr>
<td>FR</td>
<td>Failure/repeat</td>
<td>0.00</td>
<td>59 and below</td>
</tr>
</tbody>
</table>
For calculation of final course grades, decimal values are rounded up to the next whole number. If .5 or above or rounded down to the whole number if below .5, e.g., 89.5 would be an “A” and 89.4 would be a “B+.”

Please note that the spring trimester concludes on May 20th, 2014. By this date, unless approved by a course director for an “I/C” (incomplete clinical) grade, fourth year students must complete and pass all competencies, requirements and missed rotations. Failure to do so will result in an “F” grade on the transcript.

Clinical evaluations will be done on all procedures using the critical error grading format for Fixed Partial Dentures.

Daily session evaluation will be necessary for all clinical procedures in Fixed Partial Dentures. Evaluation will require faculty evaluation based on a critical error format. Daily procedures will be evaluated and recorded in AxiUm.

Clinical evaluation for each case will be determined by the following scale.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>error free</td>
<td>A</td>
</tr>
<tr>
<td>3</td>
<td>minor errors</td>
<td>B</td>
</tr>
<tr>
<td>2</td>
<td>major errors (no critical errors)</td>
<td>C</td>
</tr>
<tr>
<td>1</td>
<td>critical error</td>
<td>F</td>
</tr>
</tbody>
</table>

The grades for each case will be totaled and averaged using a numerical value for each letter grade (A=4, B=3, C=2 and F=1) to determine the final grade for the case. The final grade for the clinical courses of Fixed Prosthodontics and Removable Prosthodontics will consider daily grades as well as amount of work completed. Student must complete all requirements and pass the competency examinations prior to graduation.

### Oral/Maxillofacial Surgery

<table>
<thead>
<tr>
<th>Specific Procedure Requirements</th>
<th>Quantity</th>
<th>Point Value</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine extractions</td>
<td>40</td>
<td>2</td>
<td>80</td>
</tr>
<tr>
<td>Surgical extractions</td>
<td>8</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Multi-rooted extractions</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Multi-rooted competency</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Medical risk assessment, vital signs &amp; consult competency</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Nitrous oxide analgesia</td>
<td>4</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Nitrous oxide analgesia w/ competency</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>IV anesthesia observed</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>IV anesthesia obs. competency</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Orthodontics

<table>
<thead>
<tr>
<th>Specific Procedure Requirements</th>
<th>Quantity</th>
<th>Estimated Point Value</th>
<th>Total Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment/treatment plan</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Orthodontic clinical assessment competency</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Tracing/interpretation assessment competency</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Limited treatment competency</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Point Category

- Procedure specific points: 0
- Discipline specific points: 0

TOTAL ORTHODONTIC POINTS: 0

Pediatric Dentistry

<table>
<thead>
<tr>
<th>Specific Procedure Requirements</th>
<th>Quantity</th>
<th>Estimated Point Value</th>
<th>Total Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric dentistry exam, diagnosis And treatment plan competency</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Pediatric dentistry restorative competency</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Sealant competency</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SpaxiUm maintenance evaluation competency</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Stainless steel crown competency</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lingual Arch Requirement</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Stainless Steel crown requirement</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Minimum
Required

Point Category                   Required Points

Procedure specific points                  0
Discipline specific points                 0

TOTAL PEDIATRIC DENTISTRY POINTS*          0

*Comprehensive care points are not accrued in pediatric dentistry. Students are expected to complete all patient care assigned by the department.

General Comprehensive Care

General points are accrued by completing extra work in one or more of the comprehensive care disciplines or completing patient care on a student’s assigned patients in either oral surgery of orthodontics during a student’s open clinic time.

<table>
<thead>
<tr>
<th>Specific Procedure Requirements</th>
<th>Quantity</th>
<th>Value</th>
<th>Total Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Final Case Review (FCR)</td>
<td>9</td>
<td>5</td>
<td>45</td>
</tr>
<tr>
<td>FCR Competency</td>
<td>1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Clinical Info System Competency</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Care and management competency assessment</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Special Care Competency</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Emergency Care Competency</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Note: All 10 required final case reviews MUST be completed with the patient present. Of the 10 required, 1 must be done as a competency and cannot be a full/full case.

Minimum Required Points

<table>
<thead>
<tr>
<th>Point Category</th>
<th>Required Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedure non-specific points</td>
<td>400</td>
</tr>
</tbody>
</table>

TOTAL GENERAL COMPREHENSIVE CARE POINTS       400

Additional Point Values Associated with Special Cases

In exceptional circumstances, additional points can be awarded for a procedure if a case was especially difficult and required additional patient visits. Points awarded are based upon what it would take for an average student to complete an average case. It is expected that some procedures will take longer than the average number of visits. Additional points should only be awarded if additional time required is greater than three to four visits and the patient presented with extenuating circumstances. Awarding of additional points is left to the discretion of the department chairs. The
Office of Clinical Affairs must be notified by the chair in writing when a student is going to be awarded additional points for a procedure.

Partial Credit

Partial credit will be given in cases when patients are unwilling or unable to return to SDM for comprehensive care. After the comprehensive care coordinator has confirmed that the patient is unwilling or unable to complete care, the patient is sent a letter, which states that he or she will no longer be seen at SDM. Decisions regarding partial credit are left to the discretion of the department chairs. Partial credit will be awarded only when significant progress has been documented and the patient's unavailability verified.

Point Summary

Over a student's junior and senior year the following points must be accumulated:

<table>
<thead>
<tr>
<th>Point Category</th>
<th>Minimum Required Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL DIAGNOSTIC POINTS</td>
<td>100</td>
</tr>
<tr>
<td>TOTAL PREVENTION POINTS</td>
<td>70</td>
</tr>
<tr>
<td>TOTAL PERIODONTICS POINTS</td>
<td>260</td>
</tr>
<tr>
<td>TOTAL ENDODONTIC POINTS</td>
<td>201</td>
</tr>
<tr>
<td>TOTAL GENERAL DENTISTRY POINTS</td>
<td>400</td>
</tr>
<tr>
<td>TOTAL FIXED PROSTHODONTIC POINTS</td>
<td>420</td>
</tr>
<tr>
<td>TOTAL REMOVABLE PROSTHODONTIC POINTS</td>
<td>547</td>
</tr>
<tr>
<td>TOTAL ORAL &amp; MAXILLOFACIAL SURGERY POINTS</td>
<td>84</td>
</tr>
<tr>
<td>TOTAL ORTHODONTIC POINTS</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL PEDIATRIC DENTISTRY POINTS</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL GENERAL COMPREHENSIVE CARE</td>
<td>400</td>
</tr>
<tr>
<td>TOTAL POINTS</td>
<td>2560</td>
</tr>
</tbody>
</table>

It is anticipated that during a student's junior year at least 1000 points will be obtained. The following should serve as a guideline to ensure appropriate progress in each discipline:

<table>
<thead>
<tr>
<th>Point Category</th>
<th>Minimum Required Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL DIAGNOSTIC POINTS</td>
<td>50</td>
</tr>
<tr>
<td>TOTAL PREVENTION POINTS</td>
<td>45</td>
</tr>
<tr>
<td>TOTAL PERIODONTAL POINTS</td>
<td>150</td>
</tr>
<tr>
<td>TOTAL ENDODONTIC POINTS</td>
<td>60</td>
</tr>
<tr>
<td>TOTAL GENERAL DENTISTRY POINTS</td>
<td>180</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
<td>-------</td>
</tr>
<tr>
<td>TOTAL FIXED PROSTHODONTIC POINTS</td>
<td>160</td>
</tr>
<tr>
<td>TOTAL REMOVABLE PROSTHODONTIC POINTS</td>
<td>200</td>
</tr>
<tr>
<td>TOTAL ORAL &amp; MAXILLOFACIAL SURGERY POINTS</td>
<td>45</td>
</tr>
<tr>
<td>TOTAL ORTHODONTIC POINTS</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL PEDIATRIC DENTISTRY POINTS</td>
<td>0</td>
</tr>
<tr>
<td><strong>TOTAL POINTS</strong></td>
<td><strong>955</strong></td>
</tr>
</tbody>
</table>
PATIENT ENCOUNTER FORMS

Introduction
The SDM Access to Care and Education System (AXIUM) has been designed for students, faculty and staff to easily access patient and student information, a process that begins with accurate record keeping. Proper completion of the Patient Encounter Form (PEF) is key to producing a reliable database of patient treatment information. This material describes:

- The content of the PEF;
- The mechanisms to request a patient record and PEF;
- The correct way to complete a PEF;
- The correct way to complete the treatment plan form.

Once a few forms have been completed, the procedure becomes very familiar. Remember: Accurate documentation produces a valid and reliable patient information system.

Completing the PEF
The PEF has been designed so that both patient encounters and administration activities can be indicated on the same form. In either case, the following information must be entered:

1. If a predoctoral or postdoctoral student requests the dental record, the student's ID number and name are to be entered in the PATIENT ENCOUNTER INFORMATION section located in the top right third of the form.

   Note: The GENERAL PATIENT INFORMATION section located in the top left third of the PEF will already be completed by the AXIUM Program.

2. If diagnostic procedures or definitive treatment was not performed, a faculty member confirming the patient cancellation enters his/her ID number and signs his/her name in the Patient Encounter Information section.

3. The activity, which occurs during the session for which the patient record was requested, is indicated by placing a check on the appropriate activity line in the PATIENT ENCOUNTER INFORMATION section.

4. For each diagnostic or definitive treatment procedure worked on (which is listed in the Treatment Information section, middle third of the PEF). The student must:
   - Enter the date (Start and/or Last);
   - For endodontic therapy, operative dentistry and prosthodontics, enter the Last Step completed. (See Procedure Steps). If no step was completed enter an "O." For all other procedures, this column should be left blank;
   - If the procedure was completed enter "Y" in the Completed column. If the procedure was not completed, enter an "N";
   - Have the supervising faculty member enter his/her ID number and sign the PEF (last column under Treatment Information).
5. For each diagnostic or definitive treatment procedure worked on that is not listed in the Treatment Information section of the PEF, the student, under Additions, **must:**
   - Enter the Department responsible for supervising completion of the procedure;
   - Enter the quad/tooth ID;
   - If appropriate, enter the Surfaxyums on which the procedure is performed;
   - Enter the Sequence number. This indicates the order in which the procedures are to be performed. If the patient is a comprehensive care patient, diagnostic and treatment planning procedures are always given a sequence number of 1. Procedures decided upon during treatment planning should start with the number 2. To insert a procedure between existing planned procedures do the following: if an amalgam is sequence 5, and a crown is sequence 6, a root canal and post and core inserted between the two procedures should both be sequence 5. You cannot reorder treatment without rewriting the treatment plan. (Since sequence numbers serve only as guides, having more than one procedure with the same sequence number is allowable.) Enter the Procedure Code;
   - Indicate the date (Start and/or Last);
   - For endodontic therapy, operative dentistry and prosthodontic procedures enter the Last Step completed. If no step was completed, enter an "O." For all other procedures this column should be blank;
   - If the procedure was completed enter "Y" in the Completed column. If the procedure was not completed, enter an "N";
   - Have the supervising faculty member enter his or her ID number and sign the PEF (last column under Treatment Information).

6. For each diagnostic or definitive treatment procedure being eliminated from the treatment plan:
   - Indicate the procedure to be deleted by checking the Delete column;
   - Have the supervising faculty member enter his/her ID number and sign the PEF in the last column designated.

7. If the patient is being scheduled for a recare visit:
   - Circle the Recare Interval in the Recare Information section (see lower third of the PEF);
   - Have the supervising faculty member enter his/her ID number and sign the PEF in the appropriate column.

8. If the patient is being seen for recare:
   - Fill in the date corresponding to the recare visit being completed;
   - Have the supervising faculty member enter his/her ID number and sign the PEF accordingly.
Returning the Patient Record and PEF
1. Put the completed PEF in the patient record.

2. If an administrative activity was performed, the patient record is to be returned to the Dental Record Room.

3. If patient care was delivered, the patient record is to be returned to the receptionist in the location from which the record was requested.

4. Patient records and PEFs must be returned by 5:00 p.m. on the day the patient record was retrieved.

5. Students cannot take PEFs and Grade Forms off premises of the SDM. This will assist with complying with HIPAA regulations to secure Protected Health Information (PHI) of SDM patients.

6. HIPAA, The Health Information Portability and Accountability Act require all health care providers and facilities to keep personal patient information confidential. Through the normal course of delivering care, the patient receives a Notice of RUTGERS – Rutgers School of Dental Medicine Privacy Practices for Protected Health Information.

Most of this protected information is maintained in the patient’s dental record that is safely stored adhering to State law and RUTGERS policy on record retention and storage. Some items are not maintained in the patient’s dental record that also requires protection. As such, the Office for Clinical Affairs requires that:

during the course of completing studies and a student's clinical experience, the student is expected to keep confidential all protected health and personal information about a patient. In addition to protecting the patient’s record, students must be aware that personal information exists on Patient Encounter Forms (PEFs), Grade Forms, and documents downloaded from the School's automated patient information computer program. These documents must be equally protected from being lost or seen by individuals not directly related to the patient’s treatment. Further, all PEFs, Grade Forms, and downloaded documents that contain personal patient information, including but not limited to, name, age, sex address and chart number, must be turned in to the Office for Clinical Affairs, as a part of the check out process prior to graduation.

When students commence the sign-out process for graduation, the Office for Clinical Affairs will designate a room where these documents are to be turned in, and students will need to bring with them the “Exit Form – Fourth Year Student” for sign off. Item 15 of the final Exit Form completes the last step for senior check out and specifies that all protected health information documents have been returned to the Office for Clinical Affairs. For students going through the check out process after their scheduled date of graduation and for students going through the check out process who will not be graduating must also turn in all PEFs, Grade Forms and downloaded documents to the Office for Clinical Affairs.

Completing the Treatment Plan Form
When a treatment plan is developed for a patient, a completed Treatment Plan form (Figure 3a - Prevention Patient and Figure 3b - Periodontal Patient) is returned to the Computer Room (D730). Be sure to review them. The form should be completed whenever an initial plan is developed or there are major changes to the patient's treatment plan. Completing the form accurately assures that the information stored in the computer and printed on the PEF will be dependable. Since patient appointments and student assignments are tied to each patient's treatment plans, it is essential that this step be done properly.
STANDARD ABBREVIATIONS

In the course of thoroughly and efficiently documenting a patient's treatment record or other such important documents, the use of abbreviations can be an effective tool. Below is a standardized list of abbreviations that are acceptable for use in Rutgers School of Dental Medicine documents, including, but not limited to, patient treatment records, prescriptions, medical consult forms, inter-departmental requests, consultation forms, data collection and treatment planning forms.

(To be used for making entries in patient progress notes.)

<table>
<thead>
<tr>
<th>Abbreviations</th>
<th>Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>@</td>
<td>at</td>
</tr>
<tr>
<td>aa</td>
<td>Of each (equal parts)</td>
</tr>
<tr>
<td>ACR</td>
<td>All caries removed (AC not R - all caries not removed)</td>
</tr>
<tr>
<td>ad lib</td>
<td>At leisure, as needed or desired</td>
</tr>
<tr>
<td>ADT</td>
<td>Accepted Dental Therapeutics</td>
</tr>
<tr>
<td>Ag</td>
<td>Silver; silver amalgam; silver endodontic cones</td>
</tr>
<tr>
<td>Al</td>
<td>Aluminum</td>
</tr>
<tr>
<td>al</td>
<td>Alveolar, alveolus</td>
</tr>
<tr>
<td>anesth</td>
<td>Anesthetic; anesthesia</td>
</tr>
<tr>
<td>ant.</td>
<td>Anterior</td>
</tr>
<tr>
<td>approx.</td>
<td>Approximate (ly)</td>
</tr>
<tr>
<td>ASA</td>
<td>Aspirin (acetylsalicylic acid)</td>
</tr>
<tr>
<td>Au</td>
<td>Gold</td>
</tr>
<tr>
<td>bid</td>
<td>Twice a day</td>
</tr>
<tr>
<td>BP</td>
<td>Blood pressure</td>
</tr>
<tr>
<td>buc</td>
<td>Buccal</td>
</tr>
<tr>
<td>Bx</td>
<td>Biopsy</td>
</tr>
<tr>
<td>c</td>
<td>With</td>
</tr>
<tr>
<td>C.</td>
<td>Centigrade</td>
</tr>
<tr>
<td>CA</td>
<td>Carcinoma</td>
</tr>
<tr>
<td>Ca (OH)_2</td>
<td>Calcium hydroxide</td>
</tr>
<tr>
<td>cap</td>
<td>Capsule</td>
</tr>
<tr>
<td>Carbo</td>
<td>Carbocaine</td>
</tr>
<tr>
<td>CBC</td>
<td>Complete blood count</td>
</tr>
<tr>
<td>cc</td>
<td>Cubic centimeter</td>
</tr>
<tr>
<td>CC</td>
<td>Chief complaint</td>
</tr>
<tr>
<td>cem</td>
<td>Cement, cementation</td>
</tr>
<tr>
<td>CNS</td>
<td>Central nervous system</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>comp</td>
<td>Composite</td>
</tr>
<tr>
<td>Cm</td>
<td>Crown (Au Cr, etc.)</td>
</tr>
<tr>
<td>X-bite</td>
<td>Cross bite</td>
</tr>
<tr>
<td>CVA</td>
<td>Cerebrovascular accident (stroke)</td>
</tr>
<tr>
<td>DDX</td>
<td>Differential diagnosis</td>
</tr>
<tr>
<td>o</td>
<td>Degree (°)</td>
</tr>
<tr>
<td>Dx</td>
<td>Diagnosis</td>
</tr>
<tr>
<td>dia</td>
<td>Diameter</td>
</tr>
<tr>
<td>disp</td>
<td>Dispense</td>
</tr>
<tr>
<td>D</td>
<td>Distal</td>
</tr>
<tr>
<td>dl</td>
<td>Deciliter</td>
</tr>
<tr>
<td>DMFT</td>
<td>Decayed, missing, and filled teeth</td>
</tr>
<tr>
<td>DMFS</td>
<td>Decayed, missing, and filled surfaces</td>
</tr>
<tr>
<td>doz</td>
<td>Dozen</td>
</tr>
<tr>
<td>e.g.</td>
<td>For example</td>
</tr>
<tr>
<td>Endo</td>
<td>Endodontic department/ Endodontic Treatment</td>
</tr>
<tr>
<td>ENT</td>
<td>Ears, nose, and throat</td>
</tr>
<tr>
<td>epith</td>
<td>Epithelium</td>
</tr>
<tr>
<td>equiv</td>
<td>Equivalent</td>
</tr>
<tr>
<td>et al.</td>
<td>and others</td>
</tr>
<tr>
<td>F</td>
<td>Facial (buccal or labial or tooth)</td>
</tr>
<tr>
<td>F.</td>
<td>Fahrenheit</td>
</tr>
<tr>
<td>ff</td>
<td>Following</td>
</tr>
<tr>
<td>fl.oz.</td>
<td>Fluid ounce</td>
</tr>
<tr>
<td>FMX</td>
<td>Full mouth x-rays</td>
</tr>
<tr>
<td>FPD</td>
<td>Fixed partial denture</td>
</tr>
<tr>
<td>fract (Fx)</td>
<td>Fracture</td>
</tr>
<tr>
<td>ft.</td>
<td>Foot</td>
</tr>
<tr>
<td>GI</td>
<td>Gastrointestinal (tract)</td>
</tr>
<tr>
<td>ging</td>
<td>Gingivae</td>
</tr>
<tr>
<td>gm</td>
<td>Gram</td>
</tr>
<tr>
<td>gr</td>
<td>Grain</td>
</tr>
<tr>
<td>GP</td>
<td>Gutta percha</td>
</tr>
<tr>
<td>Hb</td>
<td>Hemoglobin (hbg)</td>
</tr>
<tr>
<td>Hi BP</td>
<td>High blood pressure</td>
</tr>
<tr>
<td>H₂O₂</td>
<td>Hydrogen peroxide</td>
</tr>
<tr>
<td>hosp</td>
<td>Hospital (ized)</td>
</tr>
<tr>
<td>HxPL</td>
<td>History of present illness</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Hx</td>
<td>History</td>
</tr>
<tr>
<td>I&amp;D</td>
<td>Incision and drainage</td>
</tr>
<tr>
<td>i.e.</td>
<td>That is</td>
</tr>
<tr>
<td>ibid.</td>
<td>In the same axiUm</td>
</tr>
<tr>
<td>imp alg</td>
<td>Impression with alginate</td>
</tr>
<tr>
<td>imp RB</td>
<td>Impression rubber base</td>
</tr>
<tr>
<td>imp cpd</td>
<td>Impression with compound</td>
</tr>
<tr>
<td>imp wash</td>
<td>Impression and wash (ZOE, wax, plaster)</td>
</tr>
<tr>
<td>IC</td>
<td>Intracutaneous</td>
</tr>
<tr>
<td>IM</td>
<td>Intramuscular</td>
</tr>
<tr>
<td>IV</td>
<td>Intravenous</td>
</tr>
<tr>
<td>IO</td>
<td>Intraoral</td>
</tr>
<tr>
<td>IU</td>
<td>International unit</td>
</tr>
<tr>
<td>it</td>
<td>Joint</td>
</tr>
<tr>
<td>kg</td>
<td>Kilogram</td>
</tr>
<tr>
<td>KvP</td>
<td>Peak kilovoltage</td>
</tr>
<tr>
<td>L</td>
<td>Liter</td>
</tr>
<tr>
<td>lab</td>
<td>Laboratory</td>
</tr>
<tr>
<td>lat</td>
<td>Lateral</td>
</tr>
<tr>
<td>ligt</td>
<td>Ligament</td>
</tr>
<tr>
<td>liq</td>
<td>Liquid</td>
</tr>
<tr>
<td>m</td>
<td>Meter</td>
</tr>
<tr>
<td>ma</td>
<td>Milliamper</td>
</tr>
<tr>
<td>mand</td>
<td>Mandibular, mandible</td>
</tr>
<tr>
<td>max</td>
<td>Maxilla, Maxillary</td>
</tr>
<tr>
<td>MDR</td>
<td>Minimum daily requirement</td>
</tr>
<tr>
<td>med</td>
<td>Medicate, medicine</td>
</tr>
<tr>
<td>mg</td>
<td>Milligram</td>
</tr>
<tr>
<td>MCI</td>
<td>Myocardial infarction</td>
</tr>
<tr>
<td>ml</td>
<td>Milliliter</td>
</tr>
<tr>
<td>M</td>
<td>Mesial, mesio</td>
</tr>
<tr>
<td>MD</td>
<td>Doctor of medicine</td>
</tr>
<tr>
<td>mm</td>
<td>Millimeter</td>
</tr>
<tr>
<td>MO</td>
<td>Mesial-occlusal</td>
</tr>
<tr>
<td>MOD</td>
<td>Mesial-occlusal-distal</td>
</tr>
<tr>
<td>MOF</td>
<td>Mesial-occlusal facial</td>
</tr>
<tr>
<td>MOL</td>
<td>Mesial-occlusal lingual</td>
</tr>
<tr>
<td>MODFL</td>
<td>Mesial-occlusal distal facial lingual</td>
</tr>
<tr>
<td>N</td>
<td>Nerve(s)</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>N20</td>
<td>Nitrous oxide</td>
</tr>
<tr>
<td>neg</td>
<td>Negative</td>
</tr>
<tr>
<td>norm</td>
<td>Normal</td>
</tr>
<tr>
<td>n.p.o.</td>
<td>(Nil per os) nothing by mouth</td>
</tr>
<tr>
<td>NTBP</td>
<td>Normal temperature and blood pressure</td>
</tr>
<tr>
<td>occ</td>
<td>Occlusion, cclusal</td>
</tr>
<tr>
<td>OD</td>
<td>Oral diagnosis</td>
</tr>
<tr>
<td>o.d.</td>
<td>Every day (omni die)</td>
</tr>
<tr>
<td>ODC</td>
<td>Oral disease control</td>
</tr>
<tr>
<td>OM</td>
<td>Oral medicine</td>
</tr>
<tr>
<td>opp</td>
<td>Opposite, opposing</td>
</tr>
<tr>
<td>OR</td>
<td>Operating room</td>
</tr>
<tr>
<td>Ortho</td>
<td>Orthodontic department</td>
</tr>
<tr>
<td>OS</td>
<td>Oral Surgery department</td>
</tr>
<tr>
<td>osteo</td>
<td>Osteoplasty, osteomyelitis</td>
</tr>
<tr>
<td>oz.</td>
<td>Ounce</td>
</tr>
<tr>
<td>PAN</td>
<td>Panoramic radiograph</td>
</tr>
<tr>
<td>PDR</td>
<td>Physician's Desk Reference</td>
</tr>
<tr>
<td>PE</td>
<td>Physical evaluation</td>
</tr>
<tr>
<td>Pedo</td>
<td>Pediatric Dentistry Department</td>
</tr>
<tr>
<td>pen</td>
<td>Penicillin, pen V, pen VK</td>
</tr>
<tr>
<td>Perin</td>
<td>Periodontic department</td>
</tr>
<tr>
<td>PI</td>
<td>Present illness</td>
</tr>
<tr>
<td>PMH</td>
<td>Past medical history</td>
</tr>
<tr>
<td>PFM</td>
<td>Porcelain fused to metal</td>
</tr>
<tr>
<td>PO</td>
<td>(Post-op) post-operative</td>
</tr>
<tr>
<td>porc</td>
<td>Porcelain</td>
</tr>
<tr>
<td>post</td>
<td>Posterior</td>
</tr>
<tr>
<td>prep</td>
<td>Preparation</td>
</tr>
<tr>
<td>p.r.n.</td>
<td>As required</td>
</tr>
<tr>
<td>prog</td>
<td>Prognosis</td>
</tr>
<tr>
<td>Pros</td>
<td>Prosthodontic department</td>
</tr>
<tr>
<td>pt</td>
<td>Pint</td>
</tr>
<tr>
<td>Px</td>
<td>Prophylaxis (prophylactic scaling, polishing)</td>
</tr>
<tr>
<td>q</td>
<td>Every</td>
</tr>
<tr>
<td>qd</td>
<td>Every day</td>
</tr>
<tr>
<td>qh</td>
<td>Every hour</td>
</tr>
<tr>
<td>q3h</td>
<td>Every 3 hours</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>qid</td>
<td>Four times a day</td>
</tr>
<tr>
<td>qn</td>
<td>Every night</td>
</tr>
<tr>
<td>qt</td>
<td>Quart</td>
</tr>
<tr>
<td>rad (radiation absorbed dose)</td>
<td>A unit measuring absorbed dose of radiation</td>
</tr>
<tr>
<td>RBC</td>
<td>Red blood cells, count</td>
</tr>
<tr>
<td>RCT</td>
<td>Root canal treatment</td>
</tr>
<tr>
<td>Rd</td>
<td>Rubber dam</td>
</tr>
<tr>
<td>Res</td>
<td>Resin</td>
</tr>
<tr>
<td>RI</td>
<td>Radiolucent</td>
</tr>
<tr>
<td>RO</td>
<td>Radiopaque</td>
</tr>
<tr>
<td>Rt</td>
<td>Right</td>
</tr>
<tr>
<td>Rx</td>
<td>Treatment, “take”</td>
</tr>
<tr>
<td>s</td>
<td>Without</td>
</tr>
<tr>
<td>SBE</td>
<td>Subacute bacterial endocarditis</td>
</tr>
<tr>
<td>SGC</td>
<td>Sub-gingival curettage</td>
</tr>
<tr>
<td>sig: - (mark)</td>
<td>Heading for patient directions on a prescription</td>
</tr>
<tr>
<td>soln</td>
<td>Solution</td>
</tr>
<tr>
<td>ss</td>
<td>One-half</td>
</tr>
<tr>
<td>ssc</td>
<td>Stainless steel crown</td>
</tr>
<tr>
<td>sut</td>
<td>Suture (bss - black silk suture)</td>
</tr>
<tr>
<td>Sx</td>
<td>Symptom (ASx - asymptomatic)</td>
</tr>
<tr>
<td>T</td>
<td>Temperature</td>
</tr>
<tr>
<td>tab</td>
<td>Tablet</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TCT</td>
<td>Tissue conditioning treatment</td>
</tr>
<tr>
<td>TMJ</td>
<td>Temporomandibular joint</td>
</tr>
<tr>
<td>TRPD</td>
<td>Treatment removable partial denture</td>
</tr>
<tr>
<td>tsp</td>
<td>Teaspoon</td>
</tr>
<tr>
<td>USP</td>
<td>United States Pharmacopeia</td>
</tr>
<tr>
<td>w</td>
<td>Which</td>
</tr>
<tr>
<td>WBC</td>
<td>White blood cells (count)</td>
</tr>
<tr>
<td>wt.</td>
<td>Weight</td>
</tr>
<tr>
<td>yr</td>
<td>Year</td>
</tr>
<tr>
<td>XT</td>
<td>Extract (ion)</td>
</tr>
<tr>
<td>XP</td>
<td>Exposure of Pulp (mch. - mechanical, car-carious)</td>
</tr>
</tbody>
</table>

12/1/08
# DEPARTMENT ABBREVIATION CODES FOR TREATMENT PLANNING

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>Hygiene</td>
</tr>
<tr>
<td>RD</td>
<td>Radiology</td>
</tr>
<tr>
<td>OD / DS</td>
<td>Oral Diagnosis / Diagnostic Sciences</td>
</tr>
<tr>
<td>SC</td>
<td>Screening</td>
</tr>
<tr>
<td>OM</td>
<td>Oral Medicine</td>
</tr>
<tr>
<td>PV</td>
<td>Prevention</td>
</tr>
<tr>
<td>PE</td>
<td>Predoctoral Periodontics</td>
</tr>
<tr>
<td>EN</td>
<td>Predoctoral Endodontics</td>
</tr>
<tr>
<td>GD</td>
<td>General Dentistry</td>
</tr>
<tr>
<td>RP</td>
<td>Predoctoral Removable Prosthodontics</td>
</tr>
<tr>
<td>FP</td>
<td>Predoctoral Fixed Prosthodontics</td>
</tr>
<tr>
<td>OC</td>
<td>Predoctoral Occlusion</td>
</tr>
<tr>
<td>OR</td>
<td>Predoctoral Orthodontics</td>
</tr>
<tr>
<td>OS</td>
<td>Predoctoral Oral Surgery</td>
</tr>
<tr>
<td>PD</td>
<td>Predoctoral Pediatric Dentistry</td>
</tr>
<tr>
<td>EM</td>
<td>Emergency</td>
</tr>
<tr>
<td>NWK</td>
<td>Newark AEGD</td>
</tr>
<tr>
<td>NSP</td>
<td>Newark Special Care</td>
</tr>
<tr>
<td>GPR</td>
<td>Newark General Practice Residency</td>
</tr>
<tr>
<td>TMD</td>
<td>TMD Fellows</td>
</tr>
<tr>
<td>PEN</td>
<td>Postgraduate Endodontics</td>
</tr>
<tr>
<td>POS</td>
<td>Postgraduate Oral Surgery</td>
</tr>
<tr>
<td>POR</td>
<td>Postgraduate Orthodontics</td>
</tr>
<tr>
<td>PPD</td>
<td>Postgraduate Pediatric Dentistry</td>
</tr>
<tr>
<td>PPE</td>
<td>Postgraduate Periodontics</td>
</tr>
<tr>
<td>PPR</td>
<td>Postgraduate Prosthodontics</td>
</tr>
<tr>
<td>FAC</td>
<td>Faculty Practice</td>
</tr>
</tbody>
</table>
TOOTH LOCATION ABBREVIATION CODES

Tooth numbers are location codes (i.e., 1,2,3...31,32, a,b,c,...s,t). In addition, the following codes are valid location codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>FM</td>
<td>Full mouth</td>
</tr>
<tr>
<td>UR</td>
<td>Upper right quadrant</td>
</tr>
<tr>
<td>UL</td>
<td>Upper left quadrant</td>
</tr>
<tr>
<td>UA</td>
<td>Upper anterior</td>
</tr>
<tr>
<td>LL</td>
<td>Lower left quadrant</td>
</tr>
<tr>
<td>LR</td>
<td>Lower right quadrant</td>
</tr>
<tr>
<td>LA</td>
<td>Lower anterior</td>
</tr>
<tr>
<td>MX</td>
<td>Maxillary arch</td>
</tr>
<tr>
<td>MN</td>
<td>Mandibular arch</td>
</tr>
<tr>
<td>IN</td>
<td>Intraoral</td>
</tr>
<tr>
<td>EX</td>
<td>Extraoral</td>
</tr>
</tbody>
</table>
## PROCEDURAL STEPS

### Endodontic Therapy

<table>
<thead>
<tr>
<th>Step Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Access preparation completed</td>
</tr>
<tr>
<td>2 Length(s) determined</td>
</tr>
<tr>
<td>3 Final files(s)</td>
</tr>
<tr>
<td>4 Master point(s) fitted</td>
</tr>
<tr>
<td>5 Case completed</td>
</tr>
<tr>
<td>6 Post spaxiUm prepared</td>
</tr>
<tr>
<td>7 Case complete</td>
</tr>
<tr>
<td>*</td>
</tr>
</tbody>
</table>

### Fixed Prosthodontics

<table>
<thead>
<tr>
<th>Step Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Diagnostic cast</td>
</tr>
<tr>
<td>2 Preparation</td>
</tr>
<tr>
<td>3 Temporization</td>
</tr>
<tr>
<td>4 Impression</td>
</tr>
<tr>
<td>5 Casting try-in</td>
</tr>
<tr>
<td>6 Solder index</td>
</tr>
<tr>
<td>7 Final restoration</td>
</tr>
<tr>
<td>8 Final cementation</td>
</tr>
</tbody>
</table>

*The student will not get credit for the Endodontic procedure until the tooth is restored with a permanent or temporary filling (but must be protective in nature to prevent fracture or caries. A band is acceptable.). At this point a “Y” is recorded on the PEF.

### Removable Partial Dentures

<table>
<thead>
<tr>
<th>Step Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Design mouth preparation</td>
</tr>
<tr>
<td>2 Final impression</td>
</tr>
<tr>
<td>3 Framework try-in</td>
</tr>
<tr>
<td>4 Altered cast</td>
</tr>
<tr>
<td>5 Vertical dimension / Occlusal record</td>
</tr>
<tr>
<td>6 Wax Try-in</td>
</tr>
<tr>
<td>7 Delivery</td>
</tr>
<tr>
<td>8 Post Operative care</td>
</tr>
<tr>
<td>9 Case complete</td>
</tr>
</tbody>
</table>

### Full Dentures

<table>
<thead>
<tr>
<th>Step Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Diagnosis / Oral examination</td>
</tr>
<tr>
<td>2 Preliminary impression</td>
</tr>
<tr>
<td>3 Final impression</td>
</tr>
<tr>
<td>4 Vertical dimension / Centric Relation</td>
</tr>
<tr>
<td>5 Wax Try-in</td>
</tr>
<tr>
<td>6 Delivery</td>
</tr>
<tr>
<td>7 Post Operative Care</td>
</tr>
<tr>
<td>8 Case complete</td>
</tr>
<tr>
<td>*</td>
</tr>
</tbody>
</table>
**Figure 1 - Patient Encounter Form - Perio**

**General Patient Information**
- Patient: 11-0001 Peter Patient
- Assigned Student: Treating Student Name/ID 89025 – Samuel Student

**Provider**
- Payment Code: RG REGULAR FEES
- Starting Balance: $0.00
- Charges: $40.00
- Payments: $40.00
- Balance: $5.00

**Payment Code: RG REGULAR FEES**
- Faculty Name/ID

**Charges**
- $40.00

**Activity (Check one):**
- Regular Patient Care: X RC

**Date**
- 02/05/93

**Session**
- PM

**Last Seen**
- 01/25/93

**Medical Alert**
- No

**Treatment Information**

<table>
<thead>
<tr>
<th>Dpt</th>
<th>Tooth</th>
<th>Suf Seq Code</th>
<th>Description</th>
<th>Date</th>
<th>Start/</th>
<th>Last/</th>
<th>Last/</th>
<th>Fee/</th>
<th>Comp.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC</td>
<td>FM</td>
<td>1</td>
<td>10101</td>
<td>01/15/04</td>
<td>01/15/04</td>
<td></td>
<td>1</td>
<td>$10</td>
<td>Y</td>
</tr>
<tr>
<td>SC</td>
<td>FM</td>
<td>1</td>
<td>00210</td>
<td>01/15/04</td>
<td>01/15/04</td>
<td></td>
<td>1</td>
<td>$30</td>
<td>Y</td>
</tr>
<tr>
<td>OD</td>
<td>FM</td>
<td>1</td>
<td>00150</td>
<td>01/20/04</td>
<td>01/25/04</td>
<td>2</td>
<td>0</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>PE</td>
<td>FM</td>
<td>2</td>
<td>14001</td>
<td>02/05/04</td>
<td>02/05/04</td>
<td>1</td>
<td>0</td>
<td>Y</td>
<td></td>
</tr>
<tr>
<td>PE</td>
<td>UR</td>
<td>2</td>
<td>04241</td>
<td>02/15/04</td>
<td></td>
<td></td>
<td></td>
<td>Y</td>
<td>Faculty Signature: ###</td>
</tr>
<tr>
<td>PE</td>
<td>UL</td>
<td>2</td>
<td>04241</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PE</td>
<td>LL</td>
<td>2</td>
<td>04241</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PE</td>
<td>LL</td>
<td>2</td>
<td>04241</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PE</td>
<td>FM</td>
<td>2</td>
<td>14002</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Reevaluation exam – type II</td>
</tr>
<tr>
<td>FP</td>
<td>14</td>
<td>4</td>
<td>04249</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Crown lengthening Surgery</td>
</tr>
<tr>
<td>FP</td>
<td>14</td>
<td>5</td>
<td>02790</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Crown – full cast</td>
</tr>
<tr>
<td>OD</td>
<td>FM</td>
<td>6</td>
<td>10998</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Final Case Complete Exam</td>
</tr>
</tbody>
</table>

**Additions**

<table>
<thead>
<tr>
<th>Date</th>
<th>Start/</th>
<th>Last/</th>
<th>Last/</th>
<th>Fee/</th>
<th>Comp.</th>
</tr>
</thead>
</table>

**Recare Information**

<table>
<thead>
<tr>
<th>Recare Type</th>
<th>Last Completed</th>
<th>Recare Visit Due</th>
<th>Date Completed</th>
<th>(0=Stop circle)</th>
<th>Faculty Signature/ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chart Audit</td>
<td>None</td>
<td>None</td>
<td>0 3 6 9 12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial Audit</td>
<td>None</td>
<td>None</td>
<td>0 3 6 9 12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maintenance</td>
<td>None</td>
<td>None</td>
<td>0 3 6 9 12</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Plaque Index Information**

<table>
<thead>
<tr>
<th>Plaque Index</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>/___/</td>
</tr>
</tbody>
</table>

**Bleeding Index Information**

<table>
<thead>
<tr>
<th>No of teeth</th>
<th>Bleeding Points</th>
<th>Bleeding Index</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>/___/</td>
</tr>
</tbody>
</table>

**Patient Reassignment**

<table>
<thead>
<tr>
<th>Patient Status Change: CA CR LA LR EM IN</th>
</tr>
</thead>
</table>
Figure 1a. Periodontic Patient

F

Chart No.: ________________  Patient Name: ____________________  Date: ________
Student ID No.: ___________  Student' Name ___________________  Medical Alert: □ Yes □ No
Faculty ID No.: ___________  Faculty Name: ____________________

<table>
<thead>
<tr>
<th>Department</th>
<th>Quadrant</th>
<th>Tooth</th>
<th>Surface</th>
<th>Sequence No.</th>
<th>ADA Procedure Number</th>
<th>Description of Service</th>
<th>Estimated Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>PE</td>
<td>FM</td>
<td>2</td>
<td></td>
<td>1 4 0 0 1</td>
<td></td>
<td>Periodontal Exam and Diagnosis</td>
<td>$20.00</td>
</tr>
<tr>
<td>PE</td>
<td>UR</td>
<td>2</td>
<td></td>
<td>0 4 3 4 1</td>
<td></td>
<td>Scaling</td>
<td>$60.00</td>
</tr>
<tr>
<td>PE</td>
<td>UL</td>
<td>2</td>
<td></td>
<td>0 4 3 4 1</td>
<td></td>
<td>Scaling</td>
<td>$60.00</td>
</tr>
<tr>
<td>PE</td>
<td>LL</td>
<td>2</td>
<td></td>
<td>0 4 3 4 1</td>
<td></td>
<td>Scaling</td>
<td>$60.00</td>
</tr>
<tr>
<td>FE</td>
<td>FM</td>
<td>3</td>
<td></td>
<td>1 4 0 0 2</td>
<td></td>
<td>Reevaluation exam – Type 11</td>
<td>$0</td>
</tr>
<tr>
<td>FP</td>
<td>14</td>
<td>4</td>
<td></td>
<td>0 4 2 4 9</td>
<td></td>
<td>Crown lengthening Surgery</td>
<td>$350.00</td>
</tr>
<tr>
<td>FP</td>
<td>14</td>
<td>5</td>
<td></td>
<td>0 2 7 9 0</td>
<td></td>
<td>Crown – Full Cast</td>
<td>$295.00</td>
</tr>
<tr>
<td>OD</td>
<td>FM</td>
<td>6</td>
<td></td>
<td>1 0 9 9 8</td>
<td></td>
<td>Final Case Complete Exam</td>
<td>$-</td>
</tr>
</tbody>
</table>

**TREATMENT PLAN**

I, ____________________ hereby make application for examination and treatment at the University of Medicine of New Jersey, Rutgers School of Dental Medicine for _______________________________ to conditions stipulated by the Dental School. It has been explained to me and I understand that the professional fee of _______ for services is based upon the treatment plan which has been discussed with me on this date.

I understand that payment is due for all services at the time of delivery. I further understand that the New Jersey Dental School will not institute a course of treatment on any irreversible procedure where a laboratory fee will be generated unless I agree to pay one-third (1/3) of the fee before the work is started, one-third (1/3) of the fee before the work is sent to the laboratory and the balance of the fee before the work is inserted.

I agree to make the necessary payments and have been advised that the Rutgers School of Dental Medicine will be unable to provide these services unless the necessary payments have been made.

________________   ___________   ________________   _____
Patient’s Signature         Date      Faculty Witness                         Date

________________   ______  ______________________  ___________   ________________   _____
Student Signature         Date
### General Patient Information

- **Patient:** 11-0001 Peter
- **Assigned Student:**

### Patient Information

- **PEF Number:** 93-000004

### Provider Information

- **Treating Student Name/ID:** 89-023 Sally
- **Faculty Name/ID:**

### Payment Information

- **Starting Balance:** $0.00
- **Charges:** $40.00
- **Payments:** $35.00
- **Balance:** $5.00
- **Adjustments:** $0.00

### Treatment Information

<table>
<thead>
<tr>
<th>Quad/Dpt</th>
<th>Tooth</th>
<th>Suf Code</th>
<th>Description</th>
<th>Start Date</th>
<th>Last Date</th>
<th>Last Step</th>
<th>Fee</th>
<th>Proc</th>
<th>Y/N</th>
<th>Faculty Sign/ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC FM</td>
<td>1</td>
<td>10101</td>
<td>Screening Exam</td>
<td>01/15/04</td>
<td>01/15/04</td>
<td>1</td>
<td>$10</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SC FM</td>
<td>1</td>
<td>00210</td>
<td>Complete Series x-ray</td>
<td>01/15/04</td>
<td>01/15/04</td>
<td>1</td>
<td>$30</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OD FM</td>
<td>1</td>
<td>00150</td>
<td>Data Collection and Tx Plan</td>
<td>01/20/04</td>
<td>01/25/04</td>
<td>2</td>
<td>$ 0</td>
<td>Y</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PV FM</td>
<td>2</td>
<td>01330</td>
<td>Initial oral hygiene exam and instr</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>EN 15</td>
<td>3</td>
<td>03330</td>
<td>Molar Root Canal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GD 28</td>
<td>4</td>
<td>02140</td>
<td>Amalgam - 1 surfaxiUm</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GD 29</td>
<td>0</td>
<td>02160</td>
<td>Amalgam - 3 surfaxiUms</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GD 29</td>
<td>MOB</td>
<td>02951</td>
<td>Pin (in addition to amalgam)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FP 13</td>
<td>5</td>
<td>06750</td>
<td>Crown Retainer - PFM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FP 14</td>
<td>5</td>
<td>06240</td>
<td>Pontic - PFM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FP 15</td>
<td>5</td>
<td>06750</td>
<td>Crown Retainer - PFM</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OD FM</td>
<td>6</td>
<td>`0998</td>
<td>Final Case Complete Exam</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Recare Information

<table>
<thead>
<tr>
<th>Recare Type</th>
<th>Last Completed</th>
<th>Recare Visit Due</th>
<th>Date Completed</th>
<th>Recare Interval</th>
<th>Faculty Signature/ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chart Audit</td>
<td>None</td>
<td>None</td>
<td><strong>/</strong>/__</td>
<td>0 3 6 9 12</td>
<td></td>
</tr>
<tr>
<td>Financial Audit</td>
<td>None</td>
<td>None</td>
<td><strong>/</strong>/__</td>
<td>0 3 6 9 12</td>
<td></td>
</tr>
<tr>
<td>Maintenance</td>
<td>None</td>
<td>None</td>
<td><strong>/</strong>/__</td>
<td>0 3 6 9 12</td>
<td></td>
</tr>
</tbody>
</table>

### Plaque Index Information

<table>
<thead>
<tr>
<th>Plaque Index</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>/</strong>/__</td>
</tr>
</tbody>
</table>

### Bleeding Index Information

<table>
<thead>
<tr>
<th>No of teeth</th>
<th>Bleeding Points</th>
<th>Bleeding Index</th>
<th>Date Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>/</strong>/__</td>
</tr>
</tbody>
</table>

### Patient Reassignment

- **Patient Status Change:** CA CR LA LR EM IN
Figure 2a - Prevention Patient

F

Chart No.: 11 / 0001  Patient Name: Peter Patient Date: 1 / 20 / 04

Student ID No.: 89023  Student' Name Sally Student  Medical Alert:  □ Yes □ No

Faculty ID No.: # # # #  Faculty Name: Dr. J. Faculty

<table>
<thead>
<tr>
<th>Department</th>
<th>Quadrant Tooth</th>
<th>Surfaxi Um</th>
<th>Sequence No.</th>
<th>ADA Procedure Number</th>
<th>Description of Service</th>
<th>Estimated Fee</th>
</tr>
</thead>
<tbody>
<tr>
<td>PV</td>
<td>FM</td>
<td>2</td>
<td>0 1 3 3 0</td>
<td>Oral Hygiene Exam</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>PV</td>
<td>FM</td>
<td>2</td>
<td>0 1 3 3 0</td>
<td>Adult Prophy</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>EN</td>
<td>15</td>
<td>3</td>
<td>0 3 3 3 0</td>
<td>Root Canal</td>
<td>275</td>
<td></td>
</tr>
<tr>
<td>GD</td>
<td>28</td>
<td>0</td>
<td>4 0 2 1 4 0</td>
<td>Amalgam - 1 SurfaxiUm</td>
<td>38</td>
<td></td>
</tr>
<tr>
<td>GD</td>
<td>29</td>
<td>MOB</td>
<td>4 0 2 1 6 0</td>
<td>Amalgam - 3 SurfaxiUm</td>
<td>55</td>
<td></td>
</tr>
<tr>
<td>GD</td>
<td>29</td>
<td>4</td>
<td>0 2 9 5 1</td>
<td>Pin</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>FP</td>
<td>13</td>
<td>5</td>
<td>0 6 7 5 0</td>
<td>Crown Retainer – PFM</td>
<td>295</td>
<td></td>
</tr>
<tr>
<td>FP</td>
<td>14</td>
<td>5</td>
<td>0 6 2 4 0</td>
<td>Pontic – PFM</td>
<td>295</td>
<td></td>
</tr>
<tr>
<td>FP</td>
<td>15</td>
<td>51</td>
<td>0 6 7 5 0</td>
<td>Crown Retainer – PFM</td>
<td>295</td>
<td></td>
</tr>
<tr>
<td>00</td>
<td>FM</td>
<td>6</td>
<td>1 0 9 9 8</td>
<td>Final Case Review</td>
<td>-0-</td>
<td></td>
</tr>
</tbody>
</table>

**TREATMENT PLAN**

I, Peter Patient hereby make application for examination and treatment at the University of Medicine of New Jersey, New Jersey Dental School for Self to conditions stipulated by the Dental School.

It has been explained to me and I understand that the professional fee of $1,293.00 for services is based upon the treatment plan which has been discussed with me on this date.

I understand that payment is due for all services at the time of delivery. I further understand that the Rutgers School of Dental Medicine will not institute a course of treatment on any irreversible procedure where a laboratory fee will be generated unless I agree to pay one-third (1/3) of the fee before the work is started, one-third (1/3) of the fee before the work is sent to the laboratory and the balance of the fee before the work is inserted.

I agree to make the necessary payments and have been advised that the Rutgers School of Dental Medicine will be unable to provide these services unless the necessary payments have been made.

Signature of Peter Patient 1/20/93  Signature of Dr. Faculty 1/20/93  Signature of Sally Student 1/20/93

Patient's Signature Date  Faculty Witness Date  Student Signature Date
PATIENT RECORDS
Dental patient records are legal documents that contain the dental treatment record of the listed patient. Confidentiality procedures established by the University, HIPAA (Health Insurance Portability and Accountability Act of 1996) and the Patient Rights and Responsibilities are to be strictly followed. The following protocol applies for patient records.

- No active patient may commence treatment without a dental record with the proper documentation: completed medical history, screening appointment, fully approved treatment plan, and the patient’s signature on both the consent form and treatment plan form.
- All patient records (including radiographs) must remain in the dental record. All dental record pages must remain in the correct order as issued. Additional pages, plaxiUmd in the appropriate section of the dental record, may be obtained from the receptionist.
- Students are responsible for verifying that each patient has signed an Informed Consent Statement and that SDM faculty or staff has witnessed it.
- No student is to write on the faxiUm of the dental record or on the “Additional Admission Notes and Consultation Sheet.”
- Students are responsible for verifying that each treatment procedure is entered in the patient record at each scheduled appointment and signed by the faculty who supervised the care. This pertains to the treatment record page, treatment plan page and the Patient Encounter Form (PEF) and must include a faculty signature for every patient cancellation or disappointment.
- Dental records are to be marked on the treatment record page each clinical session with appropriate remarks relating to the treatment according to the dental record entry system.

Dental Record Entry System (S.O.A.P.A.)

Description
All dental record entries are to be made in the “Treatment Record” form using a specific format (S.O.A.P.A.) as outlined below. The rules and S.O.A.P.A. format are as follows:

Rules

1. All entries are to be made in pen and are to be in legible handwriting; otherwise in print. Signatures must be legible. If illegible, the name must be printed below the signature. All signatures must be accompanied by faculty and student identification numbers.

2. No lines on the dental record are to be skipped. If a mistake is made, draw a line through the entry, initial it and then write the corrected entry. Keep all entries as objective as possible. Every entry must be dated and signed by a faculty member.

3. Patient name and chart number should appear on the top portion of every page in the dental record.
S.O.A.P.A. Format

1) S = Subjective

Subjective Information is the information the patient tells you including information the patient entered on the medical history and demographic chart forms. This information includes, but is not limited to medical history, social history, family history, age, sex, x-rays, and patient's chief complaint (pain, etc.), any changes in the patient's medical history, any medication(s) the patient reports to be taking or has taken prior to and/or in preparation for the dental visit (i.e., premedication, allergies to medications or materials, etc.).

2) O = Objective

Objective information is the information that you the provider discover. This information includes, but is not limited to Blood Pressure, Pulse, Respiration, Temperature, Weight, Specific Intraoral & Extraoral Examination findings (such as, swelling or luxations, decay, fractured cusp, broken clasp, notable radiographic findings, etc.). If something notable has appeared in the oral examination, it should be noted in this section of the chart entry.

3) A = Assessment

First, state your Definitive or Differential Diagnosis (e.g., necrotic pulp, irreversible pulpitis leading to un-restorable #19).
Second, please your statement about your conversation with the patient concerning the patient’s risk, benefits, alternative treatments and fee differentials.
Third, state what you plan on doing – (i.e., Extract #19, 20, 21 under local anesthesia) or MOD Amalgam on #20 with local anesthesia.

4) P = Procedure

State exactly what treatment you performed in the order in which they were performed. This entry should include the name, amount, dosage of each medication administered to the patient, (e.g., Given 2 carpules of 2% lidocaine (72mm) w/ epi 1:100,000. If none was given, then note as a pertinent negative i.e., no meds or no anesthesia given. (Also note: "as per the patient request," if it is the patient who desires no anesthetic.)

This description of the procedure performed should also include the materials used (e.g., prep temp cement with temp bond, impression with impergum. Prescription given with Post-Op instructions.
N.V. (next visit) what is to be accomplished? This should also include any problems or complications that occurred during the procedure and any other information given to or discussed with the patient as a follow up to the current procedure.

5) A = Attending:

The last line of this entry must be printed legibly and needs to state the faculty you worked with using the following format: “My attending faculty today was Dr. ____________ and Faculty ID # ______________.”

SOAPA Format Examples:
Emergency Patient

S: 43-year-old female with history of hypertension presents with chief complaint of pain and swelling on lower right for past 3 days. Patient takes Lesinopril 10 mg. 1X/day.

O: Patient’s blood pressure today is 130/85, pulse 68 and regular, respirations normal, Temp 98.6. Number 30 severe mesial-buccal decay through the furcation, Periapical pathology present.

A: Acute periapical abscess tooth number 30 requires endodontic therapy or extraction. Reviewed with patient their risks, benefits and alternative treatments including fee differentials.

P: Emergency oral exam, reviewed medical history, 1 periapical radiograph tooth number 30. Consultation with patient regarding treatment options including root canal, post and core and crown vs. extraction. Tooth replaciUment options include implant, bridge and partial explained. Patient elects extraction. Gave 1.5 carpules of lidocaine hcl 2% w/ 1:100,000-epi-block injection. Extracted number 30, no complications, hemostasis achieved, post ops given. Patient informed of her need of other dental treatment and advised to seek dental care.

A: My attending today was Dr. Bond, 007

Continuation of treatment

S: Patients presents for planned treatment. No change in medical history, patient stated he/she pre-medicated with 4 tabs Amoxicillin 500 mg 1 hour prior.

O: Patient scheduled for MOD amalgam number 30.

A: Existing defective DO amalgam with new severe caries on MO. Reviewed with patient their risks, benefits and alternative treatments including fee differentials.

P: Gave 1 carpule carbocaine hcl 3% w/o epi, plaxiUmd rubber dam, prepped MOD number 30, mesial-occlusal portion very deep plaxiUmd vitrabond, etched and bonded with tenure. PlaxiUmd amalgam. Removed rubber dam, checked occlusion and contacts. Informed patient of possible need for endo treatment. N.V. ask patient about discomfort # 30 and ML composite #8. Reminded patient to take pre-med 1 hour prior to next visit.

A: My attending today was Dr. Bond, 007
BUSINESS CARD

The use of standardized business cards is an important mechanism whereby students may communicate important information with their patients. Such information a student may wish to share with their patient is telephone contact (both personal and school), group assignment, reception area number, school address and e-mail address.

Students are reminded that it is not mandatory to share personal information with patients, and they should consider carefully the risks and benefits of sharing such information.

If a student wishes to utilize a business card, the following format must be followed. The only change a student may make is the elimination of personal or cell phone entry and personal e-mail entry. Gross deviations from the accepted format will result in the cards being confiscated and possible point deductions in Patient Care and Management.

The official RUTGERS logo is available for downloading from the RUTGERS web site.

RUTGERS
School of Dental Medicine

(Students' Name)
Doctoral Candidate in Dental Medicine

Group (?) Reception Area #
Clinic Phone 110 Bergen Street
Cell: Newark, NJ 07101
E-Mail e-mail address
PATIENT RECORD REVIEW (CHART AUDIT) PROTOCOL

QUALITY ASSURANCE PROCESS - CHART AUDITS

The chart audit is just one part of the Quality Assurance Program at the Rutgers School of Dental Medicine. It is generally acknowledged that maintenance of complete and accurate dental records is an essential element of patient care. The dental chart forms the foundation of careful diagnosis and treatment planning and provides a permanent record of treatment delivered. Continuity of care depends upon communication among providers. The dental record supplies this information and is particularly useful in settings where several practitioners may be providing care for the individual patient. Since the dental record is the most important indirect data source to aid in the evaluating of quality patient care, the maintenance of complete and accurate records is a prerequisite for Quality and Outcomes Assessment.

The audit serves three purposes. First, data obtained during the chart audit will be used to ensure that patients are receiving treatment regularly, the treatment is progressing at a proper pace, and the necessary clinical data is obtained to perform Outcomes Assessment. Second, the chart audit reinforces the necessity of the students maintaining detailed, accurate and properly completed records. Third, the chart audit ensures that all records at the Rutgers School of Dental Medicine meet Risk Management and ADA Accreditation guidelines.

The chart audit procedure developed at the Rutgers School of Dental Medicine is based upon the chart that is currently being used at the school. Examiners will specifically be looking at items regarding radiology, medical/dental history, medical alert/consult, treatment plan/clinical evaluation, perio or prevention charting, active care, informed consent, treatment record, record keeping and general chart attributes.

TRAINING:

Students -
During group meetings, students receive the operational definitions of the items to be chart audited and will be taught how to review their own charts by the Quality Assurance Coordinator. Students will also be taught the proper order of the forms in the chart.

In one of their group practice seminars students will be asked to bring two of their own charts and exchange his or her second chart with another student. The student will then perform a chart audit on one of the two charts they have brought. The student will then audit a chart from one of their peers. It is expected that by performing a chart audit on one of their own charts and performing a chart audit on one of their peers that students will be able to gain an understanding of exactly what a chart auditor will be looking for during the chart audit procedure. A grade for each chart audit will be determined by calculating the percentage of correct items among applicable items. 100%=A, 90%=B, 80%=C, 70%=D, 60%=E. The grades on their chart audits will be included in their final grade for Care and Practice Management. Students who continue to have outstanding audits (overdue or unreconciled) will not be allowed to practice in clinic until the chart audit has been correctly completed. Students who have completed an audit with incorrect items must rectify the incorrect items within six (6) weeks or they will not be allowed to practice in clinic until all items are rectified.

DCCs & GPAs - All current staff have served on the Quality Improvement Team for Chart Audits and will not require lengthy training. However, the Quality Assurance
Coordinator will use the standardized manual for students to train new staff should it become necessary.

**CLINIC FACULTY** - An orientation to the clinic will be held in the fall of the academic year. The Quality Assurance Coordinator will familiarize faculty with the chart audit process.

**STAFF** - All staff who access and write in charts will also receive orientation and become familiar with the QA chart audit.
When are chart audits completed?
Yearly Audits- Students are expected to complete 2 chart audits per month such that every active chart is reviewed yearly. Charts can be audited after a treatment plan has been generated. At the end of each month, the Dental Care Coordinator (DCC) will review the list of Chart Audits by student to determine if the student has completed at least 2 chart audits among their assigned patients. GPAs will be notified by DCC’s if students have fallen behind on chart audits. At the beginning of this process, charts which have not been audited within the last year are the priority and to avoid an initial burden of too many audits due, the students will be allowed 3 months to complete chart audits on all charts audits which have expired.

Transfer/Case Complete Audits- If a patient is being transferred or the case has been completed, the GPA is required to sign off on the chart audit form to ensure that the chart meets Quality Assurance guidelines at the point of transfer or at the completion of treatment.

Quality Assurance Review- The Quality Assurance Coordinator (QAC) will randomly select charts from the completed list to perform a thorough Quality Assurance (QA) review. The QAC will post a copy of the results of the QA review in each clinic to provide feedback on the maintenance of QA guidelines.

Who completes the chart audit?
Students have primary responsibility for maintaining chart completeness and accuracy. Students conduct a self-assessment of their charts by using the appropriate chart audit form. The four DCCs serve as the reviewers of the chart audit process by reviewing student self-assessment, recording corrections, and submitting the completed chart audit forms to the Office of Institutional Research for entry into the NSC Scan Tools System. Only DCC’s can submit chart audit forms to the Office of Institutional Research. If the chart is correct and the chart passes audit, the DCC will submit both sides of the chart audit form. If the DCC determines that the chart contains deficiencies, only Part 1 of the chart audit form will be submitted for scanning into the Scan Tools system and Part 2 of the chart audit form will be returned to the student notifying him/her of the deficiency. Students will have six (6) weeks to rectify any deficiencies. Once the deficiencies have been corrected, the student will re-review the chart with the DCC. If the DCC deems the chart satisfactory, Part 2 of the chart audit form will be submitted to the Office of Institutional Research with rectification noted.

How do we keep track of the chart audit process?
If the chart audit found a chart to be deficient in any area (contains missing information or responses in the “INCORRECT” column), the Scan Tools system will record the date of the initial assessment and keep track of the deficiencies. The GPA’s will be informed by the Office of Institutional Research, of students in their group who have outstanding (expired or deficient) charts.
CHART AUDIT CRITERIA AND OPERATIONAL DEFINITIONS

- Applies to information collected within 2 years of the date of the audit only, except where otherwise indicated.
- All charts starting with prefix 16 or greater will be audited. When charts with prefix of 16-20 are reactivated, a new registration form should be completed and the audit will be done from that date forward.
- Responsible party is always the student and all chart audits forms are to be reviewed and signed by the DCC unless otherwise indicated. Item is always applicable and always rectifiable unless otherwise indicated.
- If a patient is being transferred or the case has been completed, the GPA is required to sign off on the chart audit form to ensure that the chart meets Quality Assurance guidelines at the point of transfer or at the completion of treatment.

1. RADIOLOGY: Properly Labeled/Entries Made

Activity
All x-rays in the x-ray folder, regardless of date, should be taken out for review, to determine if they are properly mounted, labeled with patient’s name, chart number and dated. Read through the radiology log for the last year to check for the faculty signature with date on the request box, faculty signature on exposure box, a list of the type of films and number taken.

Correct
- If the radiographs have been properly mounted, dated and patient’s name and chart number appear on the mount.
- If the faculty request, film order and film exposure columns have been properly filled out and the radiographic record in the patient’s chart for the latest full mouth series, the latest two bitewings series and/or single periapical films are correct.

Incorrect
- If the radiographs are loose, improperly mounted or if a date and/or name or chart number does not appear on the mount.
- If a faculty signature on either the faculty request box, film order box or on the exposure box is missing; if there is no date or if the type and number of films is incorrect or missing.

Rectified
- Properly mount the radiograph and write the patient’s name and chart number on the mount. If it is clear from the patient’s chart or Radiology log when the radiograph was taken, the date should also be noted.
- Enter data in all columns for any film not listed on the log. GPAs should not sign the radiology record unless they were the actual faculty involved in the direct patient care.
Responsible party
Given that the DCC has the materials to mount radiographs, DCC’s will assist the student by mounting and labeling the radiograph but the Student will be responsible for rectifying the chart entries.

Nonrectifiable
a) If the appropriate date for unlabelled radiographs is uncertain even though the radiograph has been properly mounted and labeled with the patient’s name.  
b) Boxes without date, draw a line through the box and mark this item “non-rectifiable.”

2. MEDICAL/DENTAL HISTORY: Entries Made/Vital signs/Updated/Registration form signed and dated

Activity
a. Look at Medical/Dental History form.  
b. Look at the Patient Registration form.  
c. Look at the HIPAA label the cover of the chart.

Correct
a. If the Medical/Dental History form was completed, vital signs recorded and the form was signed by the patient, student and faculty.  The vitals must include the blood pressure as well as the arm and pulse readings and must be updated yearly and noted on the comment section on the reverse side of the health history form.  
b. If the patient has signed and dated the registration form.  
c. If the patient has signed and dated the HIPAA label.

Incorrect
a. If the form was completed and no vitals signs were recorded on the form or if yearly vital signs were not updated and recorded in the comment section of the Medical/Dental History form.  
b. If the patient, faculty or student has not signed and/or dated the Medical/Dental History form.  
c. If patient has not signed the Registration Form.  
d. If the patient has not signed and/or dated the HIPAA label.

Rectified
On patient’s next visit, 
a. The student reviews and completes the medical history form with the patient, takes and records vitals, dates and signs the medical history form, and/or obtains faculty signature as required.  
b. Have the patient sign and/or date the registration form.  
c. Give the patient a copy of HIPAA form have the patient sign and/or date the HIPAA label.

3. MEDICAL ALERT/MEDICAL CONSULT: Signed/Consult sent and returned/Medical Alert Boxes properly checked.
Activity
a. Look for the two-part Medical Consult form.
b. Look at the Medical Alert box on the Registration form, on the Treatment Plan form and the Clinical Exam/Periodontal Charting Form.

N/A
a. When both copies (original and carbon) of the Medical Consult form are blank.
b. Not applicable for patients with no medical alert.

Correct
a. When the original Medical Consult form is returned, is signed by a physician and a medical clearance entry appears on the Additional Admission Notes and Consultation sheet.
b. For patients with Medical Alert: All three Medical Alert boxes are properly marked on the Medical/Dental History form, the Treatment Plan form and the Clinical Exam/Periodontal Charting Form.

Incorrect
a. If both copies of Medical Consultation form are in the chart requesting medical clearance but the original form has not been signed by a physician.
b. If original copy of Medical Consultation form is not in the chart.
c. If signed original Medical Consultation form is in the chart but no faculty notation appears on Additional Admission Notes and Consultation sheet.
d. If one medical alert box on the three forms are marked and the others are not.

Rectified
a. Give Medical Consult form to the patient who is to take form to physician.
b. Obtain the completed and signed Medical Consult form from patient at next visit.
c. Have GPA make an entry on the Additional Admission Notes and Consultation sheet.
d. Properly mark all three medical alert boxes on all the forms.

4. CONSENT SIGNED:

Activity
Turn to the consent for treatment form.

Correct
If a patient or guardian and a witness have signed and dated the consent for treatment.
Incorrect
If a patient or guardian and/or a witness has not signed or dated the consent for treatment form.

Rectified
Have patient or guardian sign the consent form at the patient’s next visit. For date use the current date.

5. TREATMENT PLAN/CLINICAL EVALUATION: Treatment Plan Signatures / Problems List-Medical History Review Form Completed/Clinical Exam Form Completed/ Nutrition Risk/Risk Assessment Form completed

Activity
a. Turn to the yellow treatment plan to review the treatment plan and signatures on the bottom of the page.
b. For old charts: Turn to the Clinical/Occlusal Evaluation form and check that signatures and dates exist for student and faculty.
   For new charts:
   Turn to the Clinical Exam Form and check that it is properly completed.
   a. Vitals must be recorded
   b. Medical Alert should have medical condition noted when applicable.
   c. Physical Examination, ASA Classification and Cranial Nerve Exam results must be noted
   d. All items under Soft Tissue Exam must have either WNL notation or an explanation available
   c. Problems List Form: Turn to the form and check that a chief complaint is noted, that some notation is noted in the Dental Section, that signatures/IDs and dates exist for student, faculty and patient. Whenever a section of the form is Not Applicable student should enter NA in that section.
   d. Nutrition Risk/Risk Assessment Sheet: Turn to the form and check that form is completed and dated. All questions should be answered.

Correct
a. If there is a patient, faculty and student signature on the completed Treatment Plan form, each with dates. Student name/ID, Faculty name/ID, chart number and date are clear and legible.
b. For Old charts: If student and faculty have signed and dated the Clinical/Occlusal Evaluation form.
For New charts: If The Clinical Exam form is properly completed.
• Vitals are recorded
• Medical Alert has a medical condition noted when applicable
• Physical Examination, ASA Classification and Cranial Nerve Exam are noted
• All items under Soft Tissue Exam have either WNL (Within Normal Limits) notation or an explanation available.
c. Problems List form If the patient, student and faculty have signed and dated the form, a chief complaint is noted and some notation is noted in the Dental
Section. Whenever a section of the form is Not Applicable student should enter NA in that section.

d. Nutrition Risk/Risk Assessment Sheet: If the form is properly completed and dated

Incorrect

a. If the patient, faculty or student signature and/or dates are missing on the Treatment Plan sheet and/or Student name/ID, Faculty name/ID, chart number and date are not clear and legible.
b. Old Charts: If student or faculty signatures are missing on the Clinical/Occlusal Evaluation form.

New Charts: If The Clinical Exam form is not properly completed.

- Vitals are not recorded
- Medical Alert box not properly completed when applicable
- No notations noted in the Physical Examination, ASA Classification and Cranial Nerve Exam
- Not all items under Soft Tissue Exam have either WNL notation or an explanation available

c. Problems List form: If the patient, student and faculty signature and/or date is missing and/or no notation is noted on the form.
d. Nutrition Risk/Risk Assessment Sheet: If the form is not properly completed and/or dated

Rectified

a. Have patient sign and date the Treatment Plan form at next visit.
   Have student sign and date the Treatment Plan form at next visit.
   Have faculty sign and date the Treatment Plan form at next visit.
   GPAs should not sign a treatment plan unless they were the actual faculty involved in the direct patient care.
b. Old Charts: Have student and/or faculty sign and date the Clinical/Occlusal Evaluation form.
   New Charts: Properly complete the Clinical Exam Form. (see item C under Correct)
c. Problems List Have the patient, student and/or faculty sign and/or date the form at next visit and/or have the student complete the sections missing information.
d. Nutrition Risk/Risk Assessment Sheet: Have student properly complete the form at the patient’s next visit.

6. PERIO OR PREVENTION CHARTING:

Activity

Turn to the patient’s treatment plan sheet to see if the patient is to receive prevention or perio treatment. Then turn to the Clinical Exam/Periodontal Charting and the Periodontal Evaluation forms.

N/A
Edentulous patient.

Correct
a. For prevention cases, if the periodontal charting form has been filled in, as evidenced by notations.
b. For perio cases, if the Perio faculty has signed the Perio Diagnosis section of the Perio Evaluation form.
   (See section 3 on the backside of Perio Evaluation form.)

Incorrect
a. For prevention cases, if the periodontal charting form lacks any notations.
b. For perio cases, if no Perio faculty has signed the Perio Diagnosis section of the Perio Evaluation form.

Rectified
a. Dental student must complete the periodontal charting form at patient’s next visit.
b. Dental student to complete perio evaluation form and attain Perio Faculty signature on Perio Diagnosis section of the Perio Evaluation form, at patient’s next visit.
c. If dental hygienist did charting but it is not in the chart, student must obtain copy or complete charting.

7. TREATMENT RECORD: Dated with Tooth and Area/Signed/Pre-medication indicated

Activity
a. Turn to treatment record form. Look at the columns labeled "Date", “Tooth #”.
b. Review the student and instructor columns on the treatment record.
c. Premedication indicated: NA as of 1/12/2005 due to change in the chart structure. With the new HIPPA regulations, indication of pre-medication cannot be noted in the Medical Alert Box on the front cover of the chart as previously done. As a result there is presently no other area in the chart to write this notation and the reviewer who is not a physician, cannot determine if pre-medication is necessary. The Department of Clinical Affairs will be developing new forms that will include a check/notation box indicating when pre-medication is necessary.

Correct
a. If dates and tooth #/area appears in the respective column next to each treatment record notation.
b. If student and instructor signatures and IDs appear next to each treatment record notation.

Incorrect
a. If dates, tooth #/area do not appear in the respective columns by each treatment record notation.
b. If student and/or instructor signatures/IDs do not appear by each treatment record notation.

Rectified
• Student must enter missing information.
  a. For treatment performed by student: Student should sign with current date.
  b. Student obtains the appropriate faculty signature.
  c. GPAs should not sign a treatment record unless they were the actual faculty involved in the direct patient care.

8. ACTIVE CARE:
• NOT APPLICABLE

9. RECORD KEEPING: Skipped lines/Legible and in ink/Patient name & number

Activity
Look at the treatment record form and glance at all entries in the form, the order of forms in the chart and look for the patient’s name and chart number on the forms.

N/A
Always applicable.

Correct
a. If none of the lines have been skipped on the treatment record and consultation sheet.
b. If the chart is legible and all entries have been entered in ink. (“Legible” means “I can read it.”)
c. If all forms have the patients name and number written on the top.
d. If the forms appear in order.

Incorrect
a. If lines were skipped on the treatment record form and consultation sheet.
b. If the chart is not legible or if entries are in pencil.
c. If forms do not contain the patient's name and chart number.
d. If the forms do not appear in order.

Rectified
a. Draw a line through any skipped line.
b. Entries that are not legible or made in pencil are never rectifiable.
c. Enter on all forms the patient’s name and chart number.
d. PlaxiUm forms in the correct order.

Nonrectifiable
If entries were not legible or made in pencil.

10. OTHER: Any obvious deficiency not covered by the previous items

   Activity
   Look at the chart in general. Is it in good condition? Are there any other obvious defects, which require immediate attention?

   Correct
   Unless any other problems are noted.

   Incorrect
   Reviewer must specify what is incorrect.

   Rectified
   Student must correct deficiency noted above.

   Nonrectifiable
   Student must give GPA acceptable reason why it cannot be rectified.
Final Case Complete Examination Protocol

All Treatment Planning must be written so that the last procedure listed is for a Final Case Complete Examination Code 10998. Upon completion of all scheduled procedures in the patient’s treatment plan, the student will schedule an appointment to conduct a “final case complete examination.” Time permitting, this procedure could be accomplished at the same session that the last procedure of the treatment plan is completed. (Example – final adjustment on a removable partial denture is usually done fairly quickly and this would allow time to complete the final case complete examination – procedure 10998.) The Final Case Review Form should be completed in its entirety by the student, the faculty member, if he/she is the last person seeing the patient, or the Group Practice Administrator (GPA). (This final examination may be completed with any faculty member.)

- All students are expected to perform a final case complete examination as the last procedure on every patient that they complete.
- During the senior year, each senior must complete two Final Case Complete Examination Competencies. This is accomplished by checking “yes” in the competency box on the top of the Final Case Review Form. In order for a student’s Final Case Review Form to be considered a Final Case Complete Competency, it must be completed with the student’s GPA. The Final Case Complete Competency code 10995 should be entered onto the PEF in the addendum section and a “Y” entered in the “Complete” column or credit will not be given. The GPA must sign the PEF as well as the Final Case Review Form.

There are three type scenarios and are as follows:

I. Patient present and no additional treatment is identified:
- If no additional dental procedures are indicated at the time of the Final Case Complete Examination, then:
  1. The PEF’s start and completion dates are entered and a “Y” is placed in the completion column of the PEF for the code 10998.
  2. The patient’s chart status would then be changed to “CR” (complete recall) or recare status. A faculty member reviewing this PEF would then immediately know that all dental procedures have been completed.
  3. The Final Case Review Form must be completed in its entirety and signed by the faculty member.

II. Patient Present and additional treatment is identified:
- If at the time of this examination, the need for additional dental procedures is noted, then:
  1. Complete Sections I, II and questions 1-3 of Section III of the “Final Case Review Form-Patient Questionnaire”. Stop here and save the form.
  2. The start date of the PEF should be entered and an “N” placed in the completion column for the code 10998. This will make it evident that additional dental procedures are necessary prior to the patient being made CR.
  3. At this time, an addendum must be added to the treatment plan as well as the PEF indicating the necessary procedures; sequence and fees.
     - This addendum must be signed by the patient.
  4. In addition, a new payment plan to cover the above procedures must be initiated by the DCC or Financial Counselor.
  5. Upon completion of newly identified problems schedule another “final case complete examination” and continue to complete the Final Case Review Form-Patient Questionnaire you started at the precious “final case review examination”. Enter a “Y” on the PEF for the code 10998. The Final Case Review Form must be signed by the student and the faculty.
  6. The patient satisfaction questionnaire should be filled out by the patient at this time.
III. Patient not present: patient refuses or is unable to return to SDM for treatment:
   1. Delete the 10998 code and replace it with the 10999 code on the PEF.
   2. Complete the PEF with a “Y” and indicate the start date and the completion date.
   3. Complete questions 1-6, and question 8 on the Final Case Review Form, part I. Part II can only be completed if the patient is available by telephone.
   4. The student and faculty must sign the Final Case Review Form and submit the completed form.
   5. The patient satisfaction questionnaire on page 2 will not be completed.
I. To be completed by student and supervising faculty.

1. Yes ☐ No ☐ Has all proposed treatment on the PEF been marked completed (on blank lines on the PEF)?
2. Yes ☐ No ☐ Were the patient’s identified problems satisfactorily addressed?
3. Yes ☐ No ☐ Is there a balance?
   If patient is present, will the patient be paying the balance at this visit? If not, please contact the DCC or the financial counselor, but continue this review process.
   If patient is not present, give chart to DCC or financial counselor upon completion of review process so that a bill can be sent to the patient.
4. Yes ☐ No ☐ Is there a maintenance interval set; if yes, do not overwrite it. If no, set perio re-care to 3 months, prevention re-care visit to 6 months and F/F to 12 months on the PEF.

II. Yes ☐ No ☐ Head/neck and intraoral examination performed on the patient. ONLY Check “No” when using code 10999
- Patient is not present
   If yes, continue to section III
   If no, continue to section IV.

III. 1. Please indicate presence or not of the following new problems:
   Yes ☐ No ☐ medical problems
   Yes ☐ No ☐ head and neck problems
   Yes ☐ No ☐ periodontal problems
   Yes ☐ No ☐ other soft tissue problems
   Yes ☐ No ☐ hard tissue problems (i.e. caries)
   Yes ☐ No ☐ problems with restorations or prostheses
   2. Yes ☐ No ☐ Has the new treatment/s been added to the PEF as an addendum?
   3. Yes ☐ No ☐ Has the new treatment/s been added to the existing treatment plan?
   4. Complete this form and have faculty sign it if no new problems are identified.
      If new problems are identified:
      1. Add new treatment procedures, sequence and fees as addendum to PEF and have patient sign it
      2. Add new procedures to the treatment plan according to clinic protocol and have patient sign it.
      3. The start date for the final case review exam should be entered on the PEF and an “N” in the completion column.
      4. Stop here for today.

IV. Please indicate if the patient is overdue for the following supportive therapy or a maintenance visit:
   1. periodontal or prevention Yes ☐ No ☐
   2. other (endodontic check film, biopsy follow-up, etc) Yes ☐ No ☐

V. If no new problem is identified and this is the final visit for this treatment plan, enter a start date and a last date, and a “Y” in the completion column on the PEF. Enter completion date of final case review exam in the progress notes section of the patient record. The chart should be given to the DCC for change to CR (Re-care) status. Please check here ______ when completed.
VI. To be completed by student dentist and/or faculty with patient.

1. Yes ☐ No ☐ 1. Was the problem you had when you began treatment corrected?
2. Yes ☐ No ☐ 2. Are you satisfied with how your teeth feel?
3. Yes ☐ No ☐ 3. Are you free from any pain in your mouth?
4. Yes ☐ No ☐ 4. Are you satisfied with your ability to chew?
5. Yes ☐ No ☐ 5. Are you satisfied with your ability to speak clearly?
6. Yes ☐ No ☐ 6. Are you pleased with how your teeth look?

Faculty ID# __________________________  RUTGERS -
FINAL CASE REVIEW

VII. SATISFACTION SURVEY

Student:
Please detach this form from the Final Case Review form when you have the FCR examination and give it to your patient to complete.

Patient:
Please complete this Satisfaction Survey. After you have finished, please place the completed form in the Survey Box located at the reception area. Your responses will remain confidential and will NOT be seen by your student dentist or faculty member.

Please rate your experience using a 5-point scale where a ‘1’ means you strongly disagree with the statement and a ‘5’ means you strongly agree. We want you honest opinion:

<table>
<thead>
<tr>
<th></th>
<th>1 is “Strongly Disagree” – 5 is “Strongly Agree”</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Neutral</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>It took a reasonable amount of time for my treatment to be completed.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>I was very satisfied with my student dentist.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>I was very satisfied with the faculty who supervised my treatment.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>I will be coming back to the Rutgers School of Dental Medicine for periodic maintenance (cleaning).</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>I was very satisfied with the services received.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>If a close friend or relative were in need of dental care, I would recommend the Rutgers School of Dental Medicine.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>Have you recommended the Rutgers School of Dental Medicine to anyone?</td>
<td>Yes?</td>
<td>No?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8. What did you like about the Rutgers School of Dental Medicine?

______________________________________________________________________________

9. What didn't you like about the Rutgers School of Dental Medicine?

______________________________________________________________________________

Student:
Please detach this form from the Final Case Review form when you have the FCR examination and give it to your patient to complete.

Paciente:
Complete por favor este Cuestionario de Satisfacción. Después de que haya terminado, por favor colóquelo en la caja ubicado en la recepción. Sus respuestas se quedarán confidencial y no serán visto por su estudiante dental ni miembros de la facultad.

Por favor valore su experiencia utilizando una escala de 5 punto donde un "1" significa usted no esta "nada de acuerdo" con la declaración y un "5" significa que usted esta muy de acuerdo con la declaración. Deseamos una opinión honesta:

<table>
<thead>
<tr>
<th>1 is “Nada de acuerdo” – 5 is “muy de acuerdo”</th>
<th>Nada de acuerdo</th>
<th>No estoy de acuerdo</th>
<th>Neutral</th>
<th>De acuerdo</th>
<th>Muy de acuerdo</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Tomó un tiempo razonable para que terminaran mi tratamiento.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2 Estuve muy satisfecho con mi estudiante dental.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3 Estuve muy satisfecho con la facultad que supervisó mi tratamiento.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4 Regresare a la Escuela Dental de Nueva Jersey para mantenimiento periódico de limpieza.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5 Estuve muy satisfecho con los servicios recibidos.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6 Si un íntimo amigo o un pariente necesitara tratamiento dental, yo le recomendaría la Escuela Dental de Nueva Jersey.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7 ¿Ha recomendado la Escuela Dental de Nueva Jersey a alguien?</td>
<td>Sí?</td>
<td>No?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. ¿Qué le gustó de la Escuela Dental de Nueva Jersey?

______________________________________________________________________________

11. ¿Qué no le gustó de la Escuela Dental de Nueva Jersey?

______________________________________________________________________________
RECALL PROGRAM

An important component of the CPCS is a functioning patient Recare program.

Section I of this protocol outlines a Recare system for patients who have completed all their active care at SDM. Section II outlines a maintenance protocol for patients whose active care spans a period of six or more months.

Section I: Recare for Patients whose Active Care Has Been Completed

Setting the Maintenance Interval
After completion of patient care, the faculty supervising the Final Case Review (ADA Code 10998) will check to see if a maintenance interval has been set as determined by the patient's oral condition. In the Access to Care and Education System (AXIUM) there is a default setting. Default for periodontal maintenance will be six (6) months and for prevention twelve (12) months. (This may be overridden as indicated by patient care needs.)

Clinic Recare (CR) Status
After the final case review (FCR), the patient should be transferred from Clinic Active (CA) to Clinic Recare (CR) status in AXIUM. AXIUM will do this automatically with Codes 10998 and 10999 triggering the change. AXIUM provides a Recare screen for accessing data and a self-purging Recare list sortable by group, date, name or chart number. If follow-up care is needed in any discipline it will be noted in the comment area of the Recare screen so it can be done as part of the Recare cycle.

Examples:

<table>
<thead>
<tr>
<th>ADA Code</th>
<th>Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>13998</td>
<td>Endodontic Recare</td>
</tr>
<tr>
<td>05411</td>
<td>Denture Follow-up</td>
</tr>
</tbody>
</table>

Dental records for patients plaxiUmd on CR will go to the Financial Counselors for billing. Any patient with an outstanding balance will become eligible for recare only when all financial obligations are met.

Scheduling Recare for Patients with CR Status
Recare letters for patients with CR status are generated and documented through the AXIUM system, and are sent based on the maintenance interval date and school calendar as follows:
- Patients calling for appointments may be scheduled directly as Referable patients, or their information may be given to dental hygiene or dental students (ICD, incoming Third-years, or others) as determined by the GPA.
- If the patient does not respond to the Recare letter, a follow-up letter (second letter) will be sent in one (1) month. If still no response is received from the second letter, a third letter will be sent by registered mail the following month. If there is no
response to the third letter within 30 days, the patient's status will be changed from CR to inactive (IN) in the AXIUM system.

- Patients with balances receive a specific letter stating they're due for a Recare visit but have an outstanding balance (include the Recare charge) that **must** be paid at the time of the visit.

**Students/Faculty Performing Recare**

Any dental student or dental hygiene student can see a Recare patient. If a dental hygiene student begins the Recare visit, a dental student will be needed during the session to complete the Recare Treatment Plan.

Any faculty member can give a “start” for the Recare visit. The patient and the student must also sign the Recare Treatment Plan. **The GPA is responsible for assigning the faculty member to “start” and supervise the Recare visit and treatment plan.**

If the patient is a prevention patient, then the GPA assigns the supervision of the adult prophylaxis procedure to a Prevention faculty member, a faculty member from the Department of Community Health or a faculty member who is calibrated in Prevention. If the patient is a periodontal patient, then the GPA assigns the supervision of the periodontal maintenance procedure to a Periodontic faculty member or to a faculty member who is calibrated in Periodontics.

**The Recare Appointment -The Recare Treatment Plan**

At every Recare visit, data must be collected and the Recare Examination Form in the dental record completed. A faculty member must give a “start”. The patient's medical health status should be reviewed and the patient questioned as to any chief complaint. The medical history update and new vital signs should be entered in the medical update section of the dental record, and the box on the Recare sheet checked to indicate it was done. A full head and neck soft tissue examination should be performed. This should be followed by an oral hard and soft tissue examination to assess periodontal status and locate any caries or defective restorations. Only new work to be done should be charted. Periodontal data should include evaluation of tissue quality, probing depths, mobility patterns, recessions, furcations, muco-gingival defects, modified plaque index, etc., as indicated for periodontal maintenance protocol or prevention care. A problem list should be written stating all observed needs for this Recare cycle.

The AXIUM system provides a listing of all discipline follow-up care for which the patient needs recare. These procedures are to be entered on the problem list and treatment plan.

The dental hygiene student or the dental student can do the examination and charting. If the dental hygiene student is seeing the patient, he/she should complete all necessary dental hygiene paper work and see the dental hygiene faculty for evaluation of the data collection and problem list. Then, the dental hygiene student should call over a dental student from his/her team to review the oral exam and charting. The dental student should make a decision, with faculty assistance, if new radiographs are needed, and these should be ordered by the GPA or faculty member on the Radiographic Record (inside cover of dental record). Either the dental hygiene or dental student can take the radiographs.
At every recare visit, data must be collected and the Recare Examination Form in the dental record completed. The patient’s medical health status should be reviewed. The medical history update and new vital signs should be entered in the front of the dental record, and the box on the recare sheet checked to indicate it was done. A full head and neck soft tissue examination to assess periodontal status and locate any caries or defective restorations should be done. Only new work to be done should be charted. Periodontal charting should include indices and sulcular depths as indicated for periodontal maintenance or prevention care. A problem list should be written, stating all observed needs for the recare cycle.

When data collection is complete, the dental student (in collaboration with the dental hygiene student, if appropriate) should write a Recare Treatment Plan on the Treatment Plan Sheet (start a new one if needed of if plan is complex). Recare Treatment Plan should be entered into the computer by adding procedures to the PEF. Sequence number should be the next number after the highest sequence number on the PEF.

Examples:

**PREVENTION-RECARE TREATMENT PLAN**

-00120 Periodic Recare Exam $ 15.00
-01110 Prophylaxis - Adult $ 35.00
-00220 1 Bitewing $ 5.00
-00230 2nd Bitewing $ 2.00
-00230 3rd Bitewing $ 2.00
-00230 4th Bitewing $ 2.00
-02150 #14 DO Amalgam $ 35.00
-05610 RPD Repair $ 39.00
-19310 Prosthodontics Consult $ 0.00
$135.00

**PERIODONTAL MAINTENANCE - RECARE TREATMENT PLAN**

-04910 Periodontal Maintenance* $ 65.00
-00220 1 Bitewing $ 5.00
-00230 2nd Bitewing $ 2.00
-00230 3rd Bitewing $ 2.00
-00230 4th Bitewing $ 2.00
-02150 #14 DO Amalgam $ 35.00
-05610 RPD Repair $ 39.00
-19310 Prosthodontics Consult $ 0.00
$150.00

*Code 04910 includes the oral exam, clinical dental exam, periodontal exam and maintenance treatment. A Recare Treatment Plan must be written before the periodontal maintenance procedure begins.

The Recare Treatment Plan should be clearly labeled at the top "Recare Treatment Plan" and include the date, ADA codes and fees. All Recare Treatment Plans begin
with an oral examination. Usually the decision to do prevention or periodontal maintenance is made based on current findings and the patient's periodontal history. Department of Periodontics faculty should always be consulted if this is not a straightforward prevention Recare. If a time-consuming treatment planning decision is needed, a future treatment planning appointment should be scheduled. The student, a faculty member and the patient, should sign the Recare Treatment Plan at the time of presentation. (Patient should sign just below the last procedure on the plan.) Like the Final Case Review, the Recare Treatment Plan may be presented to any faculty member with a preference toward the faculty whose discipline is primarily represented in the proposed treatment. Once the plan is signed, all procedures on it **must** be added to the PEF.

**The Recare Appointment - Recare Treatment**

During the Recare appointment, home care should be reinforced routinely by the student. Unless otherwise indicated, all patients receive a prophylaxis or periodontal maintenance at the beginning of the Recare process, providing a treatment plan exists. When appropriate, the patient could be referred to other dental or hygiene students for the prophylaxis procedure. Then other treatment-planned procedures are done until the Recare cycle is complete. Students *performing care are responsible for collecting fees at the visit when procedure is performed*. If several visits are needed, the student who begins the Recare cycle, should:

- Add all procedures to the PEF;
- Mark Recare Code 00120 Y when exam is complete;
- Mark Prophy Code 00110 Y or Periodontal Maintenance Code 04190 when complete, and set a new Recare interval;
- Schedule patient for needed restorative care, refer the patient to a team member, or schedule patient as a referable patient for the next procedure in the Recare cycle. (Give patient an appointment card.)

**Procedure After Recare Cycle is Complete**

When the last treatment planned procedure for the Recare cycle is completed, the treating student should collect all fees due, if any. The AXIUM system will address setting the maintenance interval, checking financial status, etc. and the patient will continue as a SDM Recare patient.

**Section II: Maintenance For Patients In Active Care (CA Status)**

**Procedure**

The maintenance interval will be set as described above for Recare patients. (AXIUM will use over-ride defaults.) When the maintenance date occurs, a letter will be generated. AXIUM will enter the ADA Code 00120 as the next procedure to be done on the patient's PEF. The assigned student will be responsible for maintenance care.
Purpose: To set SDM policy determining release of patient information.

Responsibility: The Dean and Associate Deans of SDM are to ensure compliance with this policy. All Members of the administrative staff are to implement this policy.

Policy:
1. Authorized use of Patient Information. All patients reporting to the SDM will sign a consent form, which indicates that all written, photographic, video, audio and electronic records are to be used for the advancement of dental education and publication in scientific journals. Therefore, written consent is not required in using patient information for patient care, education and research purposes. However, the use of patient information for these purposes is limited to authorized RUTGERS-SDM personnel. Only students, faculty and staff on a NEED TO KNOW basis are permitted to view a patient's paper or electronic medical record. Thus students, faculty and staff are only permitted to view records for patients they are treating, performing research on, or using for educational material.

Patient information shall not be discussed in public locations, such as hallways or elevators.

2. Patient Access and Fees.
   - Patients may receive copies of records upon written request.
   - A fee may be charged for copies of patient records.
   - A written authorization from the patient or legal guardian is required.

Fee is waived for Medicaid Patients.

3. Patient Authorizations. Authorization to release patient information must be obtained in writing. A copy of the patient’s Authorization to Release Information form can be obtained from the Assistant Dean in the Office for Clinical Affairs. This form is to be used by patients, parents or legal guardians requesting copies of a patient record.

4. Procedure for Releasing Patient Request Information. A completed copy of the authorization form shall be sent to the Pediatric Dentistry Clinic for pediatric dentistry patients, to the Orthodontics Clinic for orthodontic patients, to the Oral Medicine Clinic for oral medicine or general practice residency patients, and to the Office for
Clinical Affairs for all predoctoral care patients. All of the above can refer their patients to Clinical Affairs who will then process request.

A copy of the authorization shall be filed in the patient record with a notation of what information was released, the date it was released, and who released it.

Prior to sending out the patient’s dental record, an “Authorization for Release of Patient Records” form must be filled out and signed by the patient.

5. Radiograph Duplication and Release of X-rays (not related to insurance claims). All requests for x-ray duplication require approval from the Office for Clinical Affairs, Assistant Dean. No duplication will occur without the proper notification in the patient’s dental record under “Additional Admission Notes” and “Consultation Sheet.”

Exemption from this approval:
- Clinical Financial Affairs Office engaged in insurance claim form submission.

Patient Access to X-rays and Fee
- Patients may receive copies of their x-rays upon written request.
- A fee is charged for copies of patient x-rays.
- A written authorization from the patient or legal guardian is required.
- No fee required for patients covered by Medicaid.

In matters of public record patient information may be released without the advance consent of the patient or his/her next of kin. (Please refer to Notice of RUTGERS-New Jersey Privacy Practices for Protected Health Information.)

Note: Matters of public record refer to those situations that are by law reportable to public authorities, such as automobile accident injuries, communicable diseases, cancer, criminally inflicted injuries, child and elder abuse, medical emergencies and adverse drug reactions.
Subpoenas served in person or received through the mail are processed by the Office for Clinical Affairs, which delivers a copy of the patient record to the RUTGERS Office of Risk Management for release to the court and/or sends copies to the attorneys. Before the record is released, the Office for Clinical Affairs will make a copy of the record.

The Rutgers School of Dental Medicine must retain original records, unless specifically requested by a court order or subpoena.

Fees for record duplication for Pre-doctoral and Post-doctoral patient records are as follows:

- Duplication of radiographs – (celluloid) $25.00
- Administrative Fee (postage, miscellaneous costs, retrieval of record) $10.00
- Paper chart copies - $1.00/page (up to $65.00 to equal no more than $100.00 for the entire record including x-rays.) $65.00

Total - $100.00

Also, any unpaid balance attributable to diagnostic services must be paid prior to release of any records.

Patient records may be sent to the patient, the patient’s attorney or authorized representative or a dentist of the patient’s choosing, upon receipt of proper authorization and approval by the Assistant Dean or the Associate Dean, Office for Clinical Affairs.
1. I hereby request and authorize RUTGERS/(List Individual Unit) to release information from the health record(s) of:

Patient’s Name                                                                        Patient’s Date of Birth
Patient’s Identification Number (if known)                                           Patient’s Social Security Number

I understand that this authorization includes permission to release information related to the history, diagnosis and/or treatment of any psychiatric problems, mental illness, drug abuse, alcoholism, sexually transmitted or communicable disease, AIDS, or test for infection with human immunodeficiency virus (HIV).

2. The requested information is to be sent to (name of doctor, hospital, person or organization where records should be sent):

Name: __________________________________________________________________________
Address: _________________________________________________________________________

3. The information to be released is and the records to be sent include (please provide dates of treatment and specific records):

4. Purpose/reason for release of records (circle): Medicare Insurance Legal Matters Marketing Fundraising Other (explain): ______________________________

5. I understand the nature of the authorization and that this authorization can be revoked at any time by the person giving authorization, with a written and dated notice, except to the extent that disclosure made in good faith has already been made prior to receipt of the revocation.

6. I understand that my treatment is not conditioned on obtaining this authorization.

7. I understand that this authorization is specific for release only to the above party and expires (90) days following the date of signature.

8. I understand that information used or disclosed may no longer be protected by the federal privacy laws.

9. I understand that I can be charged for obtaining copies of my records according to the fee schedule established in the New Jersey Administrative Code.

10. If the requested information involves mental health information, I acknowledge that I am aware that New Jersey has a statutory privilege accorded to confidential communications between a patient and a licensed psychologist and that release of such information may waive this privilege.

11. I understand if this authorization is for marketing purposes that RUTGERS may receive direct or indirect compensation.

Printed Name of Patient: ____________________________________________ Date: ________________
Signature of Patient: ________________________________________________
Printed Name of Patient’s Representative: ______________________________
Signature of Patient’s Representative: _________________________________
Relationship to Patient: _____________________________________________

Authorization For Release of Information

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY
STERILIZATION

Students are required to clean and disinfect the instruments on their set-ups prior to returning them to the group dispensary.

SDM staff members in the Sterilization Area are responsible for the sterilization of all items brought to the area from all dispensaries and various departments using the standards outlined in the RUTGERS-Rutgers School of Dental Medicine Sterilization Manual and the Infection Control Manual.

Rutgers School of Dental Medicine
Student, Family & Employee Fee Schedule
(See below for specifics on implant treatment)

Dental Students, Post-Graduate Dental Students, Dental Hygiene Students
And Their Families

1. All dental students, regardless of year, will receive treatment at no cost, except for laboratory/metal expenses incurred by the school. This includes bleaching kits.
2. Dental students may treat immediate family at Medicaid reimbursement rates. Immediate family is defined as parent(s) and siblings if student is not married and has no children or spouse and/or any children.
3. Dental students may treat all other family at the undergraduate fee schedule.
4. A dental student under the same guidelines as above may treat another dental students immediate and extended family.
5. In the event a student is under the care of a legal guardian other than a parent (grandparent, aunt, etc…) that person(s) will qualify as the immediate family.
6. Dental hygiene students may do recall visits on immediate family at no cost. Full mouth series of radiographs will be charged $25, bitewing and single films at no cost.

Dental Assisting Students and Their Families

1. All students enrolled in the dental assisting program through the SHRP may receive dental treatment at Medicaid reimbursement rates.
2. Dental assisting students family will be subject to the dental schools regular fee schedules.

Other RUTGERS Students and Their Families

1. All other RUTGERS students may receive dental treatment at Medicaid reimbursement rates.
2. All other RUTGERS students’ families will be subject to the dental schools regular fee schedules.
All University Employees and Their Families  
(Includes faculty & staff of SDM)

1. Employees and their family treated in the undergraduate clinics will be charged the regular undergraduate fees.
2. Employees and their family treated in any post-graduate clinic will be charged the regular post-graduate fees.

* Treatment for any of the above students in post-graduate clinics, the undergraduate fee schedule will be charged plus laboratory costs.  
*All family of any student who is treated in a post-graduate clinic should expect fees charged to be consistent with the department’s post-graduate fee schedules.  
*Complete implant treatment will be billed at $1000 for immediate family members, and at $1250 for extended family members per tooth replacement.  
*All student categories listed above may receive complete implant treatment at $1000 per tooth replacement.

Student Clinical Complaints

A student clinical complaint will be generally defined as:

…any student who feels they have an unfavorable issue while working in the clinic, interacting with patients or staff, or experiencing difficulty with a faculty member that they feel is unwarranted or requires third party intervention.

All students with a clinical complaint should report it to The Office for Clinical Affairs, Room D-990, 12th Avenue Pavilion, 973-972-6679. The Associate Dean or Assistant Dean for Clinical Affairs will act as the primary arbitrator of the complaint, and will act to resolve the issue with fairness to all parties involved.
# INDEX

| Administrative and Clinical Information | 1 |
| Attendance Policies for Students | 7 |
| Authorization for Release of Patient Records Form | 121 |
| Basic Life Support, CPR Certification | 34 |
| Becoming a Patient at Rutgers School of Dental Medicine | 12 |
| Best Management Practices for Amalgam Waste | 42 |
| Business Card | 97 |
| Patient Record Review (Chart Audit) Protocol | 98 |
| Chart Tracking Policy | 16 |
| Chemical Spills | 48 |

## Confidentiality

- Clinic Practice Closed Sessions (CPCS) Closed Rotations | 18 |
- Code Blue (Medical Emergency Protocol) | 19 |

## CODE Program

- Code of Professional Conduct and Ethics / SDM Honor Code |

## Comprehensive Patient Care System (CPCS)

- Contact Information | 2 |
- Dental Record Room Regulations | 13 |
- Dental Records for Review Request Form | 15 |

## Directions to Rutgers School of Dental Medicine

- Dispensaries | 40 |
- Dental Materials Protocol - Predoctoral | 46 |

## Dress Code Policy

- Drug Dispensing Protocol - Predoctoral | 46 |
- Lab Dispensary | 47 |
- Student Laboratories | 47 |

## Emergency Dental Care Protocol at RUTGERS – Rutgers School of Dental Medicine

- Final Case Complete Examination Protocol | 111 |

## Financial Responsibilities – Patient Care

- Group Meetings | 56 |
- Group Practice Meetings | 56 |

## Hearing Impaired Patients

- HIPAA |

## Hygiene Clinical Program

- Assignment of Patients to the Hygiene Student | 59 |

## Infection Control Manual
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Location of Rutgers School of Dental Medicine</td>
<td>4</td>
</tr>
<tr>
<td>Medical Emergency Drills Protocol</td>
<td>61</td>
</tr>
<tr>
<td>Medical Emergency Protocol (See Code Blue)</td>
<td>62</td>
</tr>
<tr>
<td>Parking</td>
<td>6</td>
</tr>
<tr>
<td>Patient Advocacy</td>
<td>65</td>
</tr>
<tr>
<td><strong>Patient Rights and Responsibilities</strong></td>
<td></td>
</tr>
<tr>
<td>Patient Care and Management I, II, Course Syllabus</td>
<td>22</td>
</tr>
<tr>
<td>Patient Encounter Forms (PEF)</td>
<td>79</td>
</tr>
<tr>
<td>Completing the PEF</td>
<td>79</td>
</tr>
<tr>
<td>Returning Patient Record and PEF; HIPAA – Privacy Practices</td>
<td>81</td>
</tr>
<tr>
<td>Completing the Treatment Plan Form</td>
<td>81</td>
</tr>
<tr>
<td>Department Abbreviation Codes for Treatment Planning</td>
<td>82</td>
</tr>
<tr>
<td>Tooth Location Abbreviation Codes</td>
<td>88</td>
</tr>
<tr>
<td>Procedural Steps</td>
<td>89</td>
</tr>
<tr>
<td>Patient Encounter Form – Periodontics (Figure 1)</td>
<td>90</td>
</tr>
<tr>
<td>Periodontic Patient Treatment Plan (Figure 1a)</td>
<td>91</td>
</tr>
<tr>
<td>Patient Encounter Form (Figure 2)</td>
<td>92</td>
</tr>
<tr>
<td>Prevention Patient Treatment Plan (Figure 2a)</td>
<td>93</td>
</tr>
<tr>
<td>Standard Abbreviations</td>
<td>82</td>
</tr>
<tr>
<td>Patient Records – Dental Record Entry System</td>
<td>95</td>
</tr>
<tr>
<td>S.O.A.P.A. Format</td>
<td>95</td>
</tr>
<tr>
<td>Point Requirements</td>
<td>69</td>
</tr>
<tr>
<td><strong>Radiation Manual</strong></td>
<td></td>
</tr>
<tr>
<td>Radiograph Duplication and Release of X-rays</td>
<td>118</td>
</tr>
<tr>
<td>Recare Program</td>
<td>114</td>
</tr>
<tr>
<td>Release of Patient Information</td>
<td>118</td>
</tr>
<tr>
<td>Sterilization</td>
<td>122</td>
</tr>
<tr>
<td><strong>Sterilization Manual</strong></td>
<td></td>
</tr>
<tr>
<td>Student Clinical Complaints</td>
<td>125</td>
</tr>
<tr>
<td>Student Clinical Evaluation</td>
<td>36</td>
</tr>
<tr>
<td>Student Immunization and Health Records Requirements</td>
<td>39</td>
</tr>
<tr>
<td>Student and Family Treatment Fee Policy</td>
<td>122</td>
</tr>
</tbody>
</table>