Guideline

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Oral Health Patient Record Protocol

Document Number	GL2015_017
Publication date	15-Dec-2015
Functional Sub group	Clinical/ Patient Services - Dental/Oral
Summary	The Oral Health Patient Record Protocol will result in a review of current work practices in such areas of odontogram, charting techniques and abbreviations. This will ensure dental practitioners create and maintain a high level of quality in record keeping, detailed documentation and relevant patient information.
Replaces Doc. No.	Oral Health Record Protocols - NSW [PD2008_024]
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Branch contact	Centre for Oral Health Strategy 02 8821 4316
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Director-General

GUIDELINE SUMMARY

ORAL HEALTH PATIENT RECORD

PURPOSE

The Oral Health Patient Record has been updated to assist oral health care providers within NSW Health maintain records that meet the Dental Board of Australia Guidelines on Dental Records (July 2010).[1]

KEY PRINCIPLES

The Oral Health Patient Record has been reviewed and updated to reflect a contemporary view of patient centred care. The guideline applies to dentists, dental therapists, dental hygienists, oral health therapists, dental prosthetists and dental specialists.

USE OF THE GUIDELINE

The Oral Health Patient Record will result in a review of current work practices in such areas of odontogram, charting techniques and abbreviations. This will ensure that all Oral Health practitioners create and maintain a high level of quality in record keeping including detailed documentation of relevant patient information, both current and historical.

These practices are to serve the best interests of NSW residents who access public oral health services and that contribute to their safety, confidentiality and continuity of dental care. This guideline describes the base line requirements for oral health patient records whether they are in paper-based or electronic form.

REVISION HISTORY

Version	Approved by	Amendment notes
December 2015 (GL2015_017)	Chief Health Officer - Deputy Secretary Population and Public Health	Replaces PD 2008_024. Now is a guideline that contains updates in oral health terminology and symbols
May 2008 (PD2008_024)	Chief Health Officer - Deputy Secretary Population and Public Health	New policy

ATTACHMENTS

1. Oral Health Patient Record - Procedures

[1] http://www.dentalboard.gov.au/Codes-Guidelines/Policies-Codes-Guidelines.aspx

Oral Health Patient Record Protocol

NSW GOVERNMENT Health

GUIDELINES

Issue date: December-2015

GL2015_017

CONTENTS

1 BACKGROUND

1.1 About this document

The Oral Health Record Procedures provides a standard of documentation in clinical dentistry with a list of commonly accepted abbreviations and charting symbols for both paper based and electronic software programs across NSW. Electronic software programs will differ in charting methods and symbols. It is however prudent that these charting methods and symbols provide a clear definition of presenting condition(s), treatment required and treatment provided.

This document provides an overview of the key elements of an oral health clinical record:

- Medical history
- Examination and treatment planning
- Primary and permanent odontograms and
- Charting symbols and definitions.

1.2 Key definitions

Examination	Includes the examination of both soft and hard tissues, and findings are recorded using an odontogram and/or text. The charting needs to comply with the World Dental Federation (FDI) system and should include: (i) restored teeth (tooth code, surface/s involved and materials used) (ii) sound and unrestored teeth (iii) missing teeth (iv) hard tissue and soft tissue abnormalities (v) occlusion, including tooth mobility (vi) periodontal status including periodontal pocket depth, supra-gingival calculus, sub-gingival calculus and oral hygiene status and type of prosthetic appliances present.

1.3 Evaluation framework

LHDs to put in place an audit process to ensure compliance with the minimum requirements of this guideline.

1.4 Associated NSW Health policies and guidelines

It is the role and responsibility of treating dental practitioner and supporting dental staff to read the Oral Health Patient Protocol guideline in full and implement them accordingly. This guideline is to be read in conjunction with:

- Clinical Procedure Safety
- Consent to Medical Treatment – Patient information
- Health Care Records – Documentation and Management
- Privacy Manual
- Record Management – Department of Health
- Records_ Disposal Authority (DA 25) (Use of functional) by NSW Department of Health
- State Health Forms
- Student Training and Rights of Patients

Ministry of Health policies and guidelines are public documents and are located on NSW Health website.[1]

2 KEY ELEMENTS

2.1 Patient identification

Patient identification by the dental practitioner needs to be in compliance with NSW Health Clinical Procedure Safety policy.

To ensure compliance the dental practitioner and clinical team must undertake the time out procedure and note accordingly in patient's progress notes with relevant signatures.

2.2 Medical History

The patient dental record should document a medical history as taken by the dental practitioner.

A medical history should include the following elements:

- Positive and negative responses
- Any adverse reactions, allergies, or events
- Medical history updates are to be completed at the beginning of each course of care. Check verbally, and if there are:
  - No changes, document 'medical history checked, no update' (MH – nil update)
  - Amend changes to the existing history or if necessary document a new medical history.
- Each dental practitioner has to ensure and sign off that the medical history is completed to their satisfaction.

2.3 Consent for treatment

Obtaining consent for treatment needs to be in compliance with the NSW Health 'Consent to Medical Treatment – Patient Information[2], and Multilingual Health Resources by LHD, MOH and NGOs funded by NSW Health (guidelines for production).[3]

2.4 Emergency Care

Clinical notes should indicate the following elements:

- Chief complaint/reason for attendance
- Diagnostic data
- Clinical findings
- Radiograph(s) taken
- Results of investigations – imaging, vitality tests etc
- Management plan or treatment given.

[1] www.health.nsw.gov.au/
[2] http://www.health.nsw.gov.au/policies/PD/2005/PD2005_406.html
[3] http://www0.health.nsw.gov.au/policies/GL/2005/GL2005_032.html

2.5 Examination and Treatment Plan for a Course of Care

Clinical notes should indicate the following elements:

- Presenting complaint
- Past dental history
- Full dental charting of dentition on examination when providing a full course of care
- A separate charting of treatment required (which may be amended to note the progress of treatment)
- Notes regarding:
    - Soft tissues,
    - Extra-oral findings,
    - Intra-oral findings,
    - Periodontal health,
    - Preoperative and postoperative risks and treatment options,
    - Sterilization tracking labels, and
    - Brochures, fact sheets and Oral Health Fee for Service vouchers provided, if required.
- A treatment plan of appropriate detail.

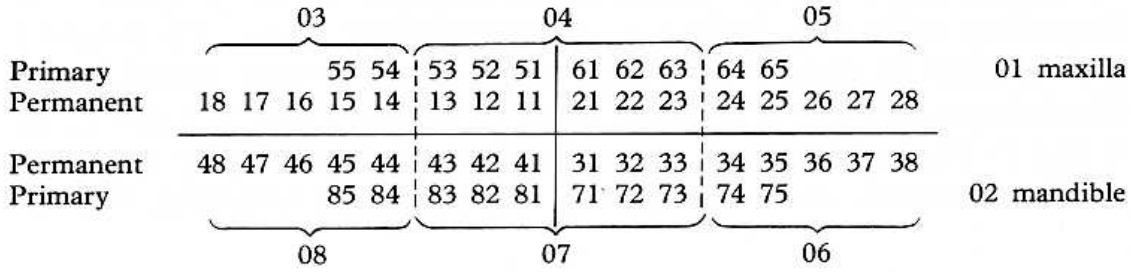
2.6 Charting and Tooth Identification

The Federation Dentaire Internationale (FDI) notation for recording tooth number is to be used (Refer to Diagram A), as follows:

Two digit codes for the jaws and sextants of the mouth are:

- 00 indicates the mouth
- 01 indicates the maxilla
- 02 indicates the mandible
- 10 to 40 indicate the quadrants in clockwise order starting on the top right.

Diagram A

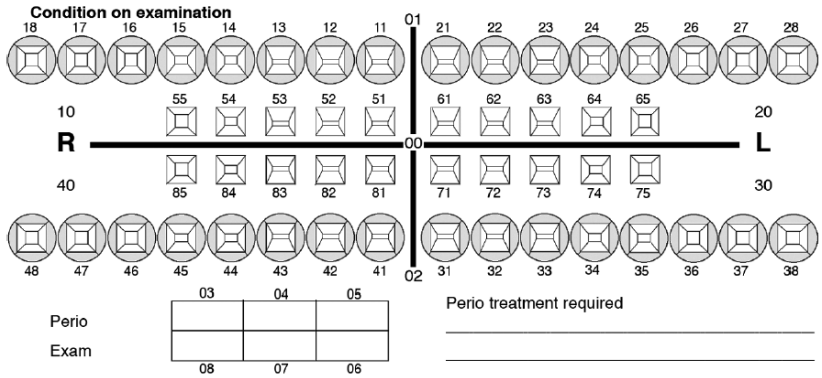


2.6.1 General Odontogram

The odontogram for permanent teeth may have root surfaces and a primary odontogram should be available where applicable (refer to Diagram B).

Diagram B

Root Surface Odontogram (Dennison, P. 1999)



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2.6.2 Periodontal Charting

When a periodontal charting is required it should include the recording of:

- Recession
- Pocket depth
- Suppuration
- Bleeding on probing
- Furcation involvement
- Mobility.

[4] Dennison, P (1999) 'A Modified Odontogram to enable Root Surface Charting' Community Oral Health and Epidemiology, Westmead Centre for Oral Health, Faculty of Dentistry University of Sydney Australia.

2.7 Anaesthetics

Clinical notes should indicate the following elements:

- Type of anaesthetic used
- Amount of anaesthetic used
- Type of injection given
- Any adverse reactions, allergies, or events.

2.8 Restorations

Clinical notes should indicate the following elements:

- Tooth involved
- Surface/s involved
- Base/linings used
- Restoration material and shades used
- Unusual depth or other features
- Pin placement, if used
- Pulp exposure (size, location, mechanical/carious), if this has occurred.

2.9 Exodontia

Clinical notes should indicate the following elements:

- Tooth to be extracted
- Reasons for extraction
- Tooth extracted
- Radiographic evidence to support decision for extraction
- Any complications
- An indication if post-operative instructions were given
- An indication if haemostasis has been achieved
- Need for review, as required.

2.10 Minor Oral Surgery

Clinical notes should indicate the following elements:

- Reason for procedure
- Procedure undertaken including technique used
- Supporting test/data/symptoms
- Any complications
- An indication if haemostasis has been achieved

- An indication if post-operative instructions were given
- Need for review, as required.

2.11 Medication

Clinical notes should indicate the following elements:

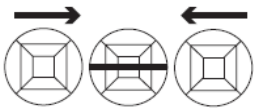
- The type of medication prescribed
- Reason for administration of prescription
- The dose of medication and indication of the method of delivery
- If antibiotic prophylaxis is used, the time of administration and the time of commencement of treatment
- Any adverse reactions, allergies, or events
- Results of antibiotic sensitivity testing, as required
- Discussions with the patient's medical practitioner.

3 TERMS, ABBREVIATIONS AND SYMBOLS

Abbreviations and symbols may vary depending on the patient record type (paper or electronic). Table 1 displays the recommended terms, abbreviations and symbols.

Table 1

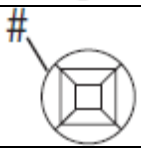
TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
ANATOMY			
Anterior	Ant		
Arrested Caries	AC		
Bilateral(ly)	bilat		
Buccal	B		
Cardiovascular System	CVS		
Caries Free	CF		

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Cemento-enamel junction	CEJ		
Central Nervous System	CNS		
Centric Occlusion	CO		
Centric Relation	CR		Contextual note
Distal	D		
Drifted Tooth			
Incisal	I		
Labial	Lab		
Lateral	Lat		
Left	L		
Left Hand Side	LHS		
Lingual	L		
Lower Left	LL		LL – not to be used when referring to teeth
Lower Right	LR		LR - not to be used when referring to teeth

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Maxillo-Mandibular Relationship/record	MMR		
Mesial	M		
Mesial-occlusodistal	MOD		Sample of combination for tooth surfaces
Missing tooth			
Occlusion (notes)	Occl		
Occlusal Vertical Dimension	OVD		
On Examination	O/E		
Over Retained	O/R		
Overbite	O/bite		
Overjet	O/jet		
Palatal	P		
Partially erupted	PE		
Posterior	Post		
Quadrant	Q		

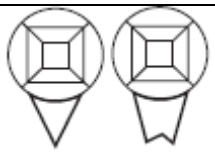
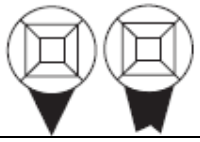
TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Quadrant, lower left	Q3		
Quadrant, lower right	Q4		
Quadrant, upper left	Q2		
Quadrant, upper right	Q1		
Secondary Caries	2°C		
Retained Root	RR		
Retruded Position	RP		
Right	R		
Right Hand Side	RHS		
Supernumery	S		
Temporo-mandibular joint	TMJ		
Unerupted	UE		
Upper Left	UL		
Upper Right	UR		

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Vertical Dimension	VD		
EXAMINATION			
Assessment	Assess		
Bite Wing radiograph/s or film/s	BW		
Cephalometry/ic	Ceph		
Cerebro-Vascular Accident	CVA		
Chief Complaint	CC		
Cigarettes	Cigs		
Community Periodontal Index of Treatment Needs	CPITN		
Complains (ing) of	C/O		
Cone Beam Imaging	CBCT		
Consultation	Consult		
Decrease (d) (ing)	↓		
Dental History	DH		Contextual note

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Diagnosis	Dx		
Differential Diagnosis	DDx		
Division	Div		
Emergency	Emerg		
Examination	Exam		
Extra-oral	E/O		
Family History	FH		
Family and Social History	F/SH		
Father	F		
Female	♀		
Fracture	#		Fractured tooth – contextual note
			Fractured root
General Dental practitioner	GDP		
General Medical Practitioner	GMP		

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
History of Present Complaint	HPC		
Increase (d) (ing)			
Intra-Oral	I/O		
Lateral Cephalometic radiograph	LCeph’		
Male			
Medical History	MH		
Mother			
Motor Vehicle Accident	MVA		
No Abnormalities Detected	NAD		
Non Vital	NV		
Occlusal radiograph/s or film/s	Occl		
On Examination	O/E		
Orthopantomogram	OPG		
Past Medical History	PMH		

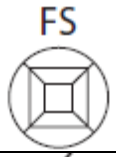
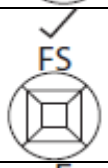
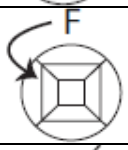
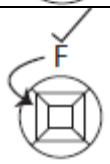
TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Periapical Film/s or Radiograph/s	PA		
Periodontal screening and recording	PSR		
Prognosis	Px		
Provisional Diagnosis	PDx		
Social History	SH		
Tender to Percussion	TTP		
Toothache	T/ache		
Treatment	Tx		
Treatment Plan	TP		
Within normal limit(s)	WNL		
ANAESTHESIA			
Inferior Alveolar Dental Block	IANB		
Infiltration	Infilt		
Local Anaesthetic	LA		

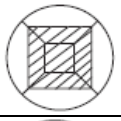
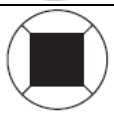
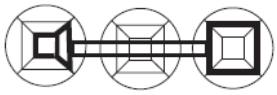
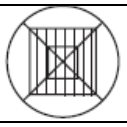
TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Nitrous Oxide	N_2O		
Relative Analgesia	RA		
ENDODONTIC			
Cotton Pellet	CP		
Endodontic (s)	Endo		
Ferric sulphate	FeSO		
Gutta Percha	GP		
Hydrogen Peroxide	H_2O_2		
Ledermix	led		
Master Apical File	MAF		
Number, size, gauge of endo file	No.		
Root Canal Therapy	RCT		
Root Filling			Root filling required
			Root filling present

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Sodium hypochlorite	NaOCl		
Working length	WL		
ORAL SURGERY			
Black Silk Suture	BSS		
Extraction or Exodontia	Exo		Tooth to be extracted
			Tooth extracted
Haemostasis Achieved	HA		
Inter-maxillary Fixation	IMF		
Interrupted Cat Gut Suture	ICGS		
Oral & Maxillo Facial Surgery	OMFS		
Oral Surgery	OS		
Post-operative instructions given	POIG		
Removal of sutures	ROS		
Surgical removal	SR		

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
ORTHODONTIC			
Cross bite	X-bite		
Full Fixed Orthodontic Appliance	FFA		
Index of Orthodontic Treatment Needs	IOTN		
Mandibular Removable Orthodontic Appliance	LRA		
Maxillary Anterior Crowding	UAC		Upper
Maxillary Removable Orthodontic Appliance	URA		
Orthodontics	Ortho		
Rapid Maxillary Expansion	RME		
PAEDIATRIC			
Paediatric dentistry	Paedo		
Pulpectomy	Pulpect		
Pulpotomy	Pulpot		
Stainless Steel	SS		

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Stainless Steel Crown	SSC		
To-be-left	TBL		
PERIODONTIC			
Acute Necrotising Ulcerative Gingivitis	ANUG		
Bleeding on Probing	BOP		
Hand Scale	H/Scale		
Loss of Attachment	LOA		
Mucogingival junction	MGJ		
Periodontics	Perio		
Root Planing	RP		Contextual comment
Subgingival	Subging		
Supragingival	Supraging		
PREVENTIVE			

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Acidulated phosphate fluoride	APF		
Fissure Sealant	FS		Fissure Sealant required
			Fissure Sealant present
Fluoride	F^-		Fluoride application required
			Fluoride application given
Mouthguard	M/guard		
Oral Health Promotion	OHP		
Oral Hygiene	OH		
Oral Hygiene Instruction	OHI		
Preventive Resin Restoration	PRR		
Prophylaxis	Prophy		
Scale & Clean	S+C		
Sodium Fluoride	NaF		

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Stannous Fluoride	SnF2		
Toothbrushing Instruction	TBI		
PROSTHETICS FIXED			
Acrylic Dentures	Acr		
Acrylic Jacket Crown	AJC		
Crown			Crown required
			Crown present (insert other examples)
Crown and Bridge	C+B		Crown and bridge required
			Crown and bridge present
Full Gold Crown	FGC		
Implant	Implant		
Metallo-ceramic restoration/metal ceramic crown	MCC		
Porcelain Jacket Crown	PJC		
Post core	P/core		

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
PROSTHETICS REMOVABLE			
Addition	Add		
Chrome Cobalt	CrCo		
Full Denture, Mandibular Only	-/F		
Full Denture, Mandibular and Maxillary	F/F		
Full Denture, Maxillary only	F/-		
Immediate Denture	Immed		
Partial Denture, Mandibular Only	-/P		
Partial Denture, Mandibular and Maxillary	P/P		
Partial Denture, Maxillary only	P/-		
Primary Impression	1^{o} Imp		
Prosthetic	Pros		
Secondary Impression	2^{o} Imp		
RESTORATIVE			

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Amalgam	Amal		
Calcium Hydroxide	Ca(OH)2		
Class	Cl		
Composite Resin	CR		
Glass Ionomer Cement	GIC		
Interim Restoration	Temp		
Intermediate restorative material	IRM		
Overhang	o/hang		
Resin Modified Glass Ionomer	RMGI		
Restoration	Rest		Restoration required – outline entire surface where lesion is identified (eg. is two surfaces)
Vitrebond	Vbond		
Zinc Oxide Eugenol	ZOE		
Zinc Phosphate	Z_nPO_4		
OTHER			

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Adjustment	Adj		
Alginate	Alg		
Biopsy	Bx		
Carbon Dioxide	CO_2		
Chlorhexidine	CHx		
Impression	Imp		
Issue	Iss		
Management	mgt		Contextual note
Not Caries Free	NCF		
Post-operative (ly)	Post-op		
Post-Operative Instructions given	POIG		
Pre-operative	Pre-op		
Prescribe	Rx		
Rubber Dam	RDam		

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Advise	Adv		
Appointment	Appt		
Date of Birth	DOB		
Dental Assistant	DA		Contextual note
Dental Hygienist	DH		Contextual note
Dental Officer	DO		Contextual note
Dental Prosthetists	DP		Contextual note
Dental Therapist	DT		Contextual note
Oral Health Therapist	OHT		
Fail to attend	FTA		
Further appointment made	FAM		
New Patient	N/P		
Next Visit	N/V		
Patient	Pt		

TERM	ABBREVIATION	charting notation (if required)	explanation (if required)
Primary Oral Care	POC		
Priority Oral Health Program	POHP		
Recall	R/C		
Refer	Ref		
Relief of Pain	ROP		
Required	Req		
Review(ed)	Rev		
School Assessment Program	SAP		
Unable to attend	UTA		
Visiting Dental Officer	VDO		
Waiting list	W/L		