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Description
These guidelines provide information for all clinicians on the management and keeping of clinical records in the Griffith University Dental Clinic. The guidelines are written to assist with continuity of patient care and to ensure that Griffith University Dental Clinic Patient Records meet legal requirements.

Related Policies and Procedures
Griffith University Student Training Materials for the Patient Management System
Griffith University Staff Training Materials for the Patient Management System

Introduction
The Griffith University Dental Clinic is located in the School of Dentistry and Oral Health, in the Centre for Medicine and Oral Health, on the Gold Coast. The Clinic treated its first patients at the end of 2005. Dental professionals, including technicians, prosthetists, therapists, hygienists and dentists are trained side-by-side in collaboration with the Medical School, and treatments are provided to members of the general public. Also professional practices, both general and specialist are operated from the clinical facilities. Because of the large number of practitioners who work within the clinic, it is essential that records are accurate created in order to ensure continuity of patient care.

The GU clinic patient records are electronic and contain patient details including their medical history, details of the treatment, advice that the patient has received and is currently receiving, and treatments planned for the future. The records computer system is secure and meets the requirements of National and State Privacy Legislation. Currently the only components of the record which are not electronic are the Medical History and Consent form which all patients complete on initial presentation to the clinic and the radiographic record. The information collected on the Medical History/Consent form is entered into the electronic patient management system (PMS) at the first appointment and this piece of paper is archived to secure storage. It is planned that radiography will become digital by the end of 2008.

Chief Complaint:
Most patients visit the dentist with complaint of pain but it may be bleeding gums, foul smell, crowding of teeth or routine recall.

Knowing more about the chief complaint not only helps in prioritising a treatment plan but it may also help in reaching the diagnosis e.g. pulpal pathology. It is important to get more information from patient/relative/carer about....

- Onset
- Precipitating/aggravating factors
- In case of pain
  - Level of pain
  - Character
  - Area of pain
  - Time characteristics
Medical Histories
Medical History/Consent forms are for screening purposes only, and serve to highlight possible significant medical problems that require further investigation. The information on the form and collected from consultation should be entered into the computer at the first appointment before the patient departs. It is a practitioner/student responsibility to obtain this information and in the case of a student it must be checked by a supervisor.

Details of the medical history that require special precautions to be taken must be acknowledged and a medical alert icon activated for the following conditions:

- Allergies
- Anticoagulant therapy
- Antibiotic cover required
- Immunosuppression
- Creutzfeld_Jacob disease

The icon is a red cross on the top of the screen. (Refer to training manual for process of activation)

Medical histories should be updated every six months and a note made in the record that this has occurred.

Social, Family and Dental Histories
It is important to appreciate that details of the social, dental and family histories are accurate only the time they are recorded; they can change considerably within a short period of time. For example, the birth of another child or change of address can affect the parent's ability to take the child to the dental surgery. It is important to keep the history up to date by further questioning at the regular 4-6 month review visits.

Some information on social, family history, especially for child patients: Name/Nick name, Address, School, Brothers and sisters, Pets, Favourite activities, Parent's occupation, Tooth brushing details.

Some information on dental history: Past dental visits and treatment done (including recalls) and oral hygiene habits (including use of interdental aids).
Charting
Every patient should have an examination. Other than for emergency treatment, any general dental patient should have a full charting and subsequent treatment plan developed. While specialist dentists are not required to undertake a full charting unless this is an integral part of their treatment, they should undertake general visual examination. Other obvious problems should be noted and the patient and referring dentist advised accordingly. Charting is generated electronically and a guide to the symbols can be found in the PMS training manual.

All full chartings should be accompanied by a Periodontal Screening and Recording Index (PSR) (Appendix F). The PSR may be recorded on the chart tab by using the following procedure:
1. Open the chart tab
2. Click on the DMF button
3. Click the ‘+’ button on the bottom right hand corner
4. Tick ‘enter CPI box’
5. Press OK
6. Enter score
7. Press OK

Note: The software is being altered so that the CPI reads PSR and this should occur during 2008

Charts for full periodontal, orthodontic and pathological observations (both intraoral and extraoral) are available in the PMS. (see training manual for operational detail). Attached at Appendix A is a standardised system for recording information on the pathology tabs.

Clinical Notes
Clinical notes are an essential component of the patients visit, and form a legal document detailing what occurred. There should be an entry on the notes page for every contact with the patient including by telephone and letter. Many cases that proceed to litigation do so some time after treatment, when the clinician’s memory of the treatment has faded. Also, the clinician may not be aware of any adverse outcome at the time, so detailed note taking becomes the only reliable means of documenting what transpired, and becomes the only means of defence in a complaints scenario. The legal requirements state that notes should be contemporaneous therefore they must be completed at the appointment when the patient is seen.

Following are some general guidelines on what should appear in the patients’ notes after each visit.
(Standardised abbreviations for recording information in GU notes is at Appendix B)

Date:
The computer software will automatically record the date. Please note however that it is a legal requirement to always enter the date that treatment is carried out, and should always be included when using traditional paper notes.

Name of Practitioner:
The computer software will automatically record each practitioner’s code beside the date and provide a computer sign off. Please note, however that it is a legal requirement to be able to identify the practitioner and the practitioner should sign the records at the end of each visit if using paper records.

Area of Treatment:
FDI notation (Appendix C) should be used to identify the tooth/teeth which are being treated.

Radiographs:
Any radiographs taken must be recorded and the number of the machine on which they were taken. If the patient is referred to specialist radiography practice outside Griffith then this must also be recorded.
Guidelines for Medical Histories and Clinical Notes

Procedural Details:
Clear concise details of the procedure undertaken should be included. Information included should be detailed and include area of the mouth in which the treatment was carried out (the tooth number may be sufficient), materials, any difficulties encountered and will vary for the type of procedure carried out.

Preoperative Warnings:
Any preoperative warnings given eg risk of paraesthesia should be noted. When appropriate warnings are given, patients are less likely to be alarmed if there is discomfort. When documented correctly, you can demonstrate these were given in the case of complaints.

Postoperative Instructions:
Any post operative instructions given should be noted. For example this may include warnings of possible swelling, discomfort, possibilities of cheek or lip biting etc.

Discussions:
Any significant discussions undertaken with the patient about options for treatment, costs and questionable prognosis of treatment should also be recorded. This is especially important during early visits when treatment plans are being formulated. Similarly, if, as does happen, the treatments plan changes during treatment, this must be documented clearly.

Medications:
Local anaesthetics administered should be recorded – this should include type of anaesthetic, dose and mode of administration. Any drugs prescribed such as analgesics or antimicrobials should be recorded. If the patient requires antibiotic cover prior to dental care then it should be recorded that the patient has taken the prescribed prophylactic dose.

Disposal of the patient:
This may take a number of forms, such as the plan for the next appointment, the review or recall period or referral to another practitioner.

Attendance:
Should the patient fail to attend, cancel their appointment, or arrive late this should also be recorded.

As a general guide, always write clinical notes with the thought that it may be someday viewed by a third party. This could be the patient, another dentist, or a patient’s legal counsel. In the event of an adverse outcome, inadequate notes can be disastrous.

Some examples of appropriate notes are given at Appendix D
References

Dental Board of New South Wales. Guidelines for Dental Record Keeping 1998; September

Dental Board of Queensland. Guidelines on Dental Records 2003; March

Elderton, R. J. Keeping up-to-date with tooth notation BDJ 1989; 166(2):55-58

Oral Health Centre of Western Australia. Patient Clinical Record Management Plan 2005


Sydney South West Area Health Services. Clinical Policy Manual, Unit File and Record Documentation 2005

Wilkinson, E. J. Modern Clinical Records ADA (NSW Branch) 2002; June – October; Parts 1-5
Appendix A  Oral Mucosal Findings Chart
by Dr. Raj Nair, Senior Lecturer, Oral Medicine

- Ulcer
- Ulcer and erosion
- Erosion
- Atrophy
- White patch
- Erythema/red patch
- Vesicle/bullae
- Desquamation
- Fibrosis/scar
### Appendix B  Abbreviations

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
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<tbody>
<tr>
<td>Acid-etch Composite Resin</td>
<td>Basal Cell Carcinoma</td>
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<tr>
<td>Acidulated Phosphate Fluoride</td>
<td>Bitewing Radiographs</td>
</tr>
<tr>
<td>Acquired Immunodeficiency Syndrome</td>
<td>Black Silk Suture</td>
</tr>
<tr>
<td>Acrylic Jacket Crown</td>
<td>Blood Pressure</td>
</tr>
<tr>
<td>Acute Myeloid Leukaemia</td>
<td>Body Weight</td>
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<tr>
<td>Adjustment</td>
<td>Bone Marrow Transplant</td>
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<td>Alginate Impression</td>
<td>Buccal</td>
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<td>Amalgam</td>
<td>Calcium Hydroxide</td>
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<td>Cancelled</td>
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<td>Appointment</td>
<td>Carcinoma</td>
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<tr>
<td>As Soon As Possible</td>
<td>Carious Exposure</td>
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<tr>
<td>Atraumatic Restorative Technique</td>
<td>Catgut Sutures</td>
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<tr>
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<td>Centric Occlusion</td>
</tr>
<tr>
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<td>Centric Relation</td>
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<tr>
<td></td>
<td>Cephalometric</td>
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<tr>
<td></td>
<td>Chest radiograph</td>
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<td>Chlorhexidine</td>
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<td>Chrome Cobalt</td>
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<td>Chronic Lymphocytic leukaemia</td>
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<td>Complains of</td>
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<tr>
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<td>Consultation</td>
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<tr>
<td></td>
<td>Crossbite</td>
</tr>
<tr>
<td></td>
<td>Crown</td>
</tr>
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<td>Date of Birth</td>
</tr>
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<td>Differential diagnosis</td>
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**Abbreviations**

- AECR: Acid-etch Composite Resin
- APF: Acidulated Phosphate Fluoride
- AIDS: Acquired Immunodeficiency Syndrome
- AJC: Acrylic Jacket Crown
- AML: Acute Myeloid Leukaemia
- Adj: Adjustment
- Alg: Alginate Impression
- Amal: Amalgam
- Ant: Anterior
- Appt: Appointment
- ASAP: As Soon As Possible
- ART: Atraumatic Restorative Technique
- BCC: Basal Cell Carcinoma
- BW: Bitewing Radiographs
- BSS: Black Silk Suture
- BP: Blood Pressure
- BW: Body Weight
- BMT: Bone Marrow Transplant
- CGS: Catgut Sutures
- CEJ: Cementoenamel junction
- CeO: Centric Occlusion
- CeR: Centric Relation
- Ceph: Cephalometric
- CXR: Chest radiograph
- CHX: Chlorhexidine
- CrCo: Chrome Cobalt
- CLL: Chronic Lymphocytic leukaemia
- CML: Chronic Myeloid Leukaemia
- Cigs: Cigarettes
- CI (I,II,IV&V): Class (I,II,III,IV, & V)
- CPITN: Clinical Periodontal Index of Treatment Need
- C/O: Complains of
- Cons: Consultation
- X-Bite: Crossbite
- Cr: Crown
- DOB: Date of Birth
- DHE: Dental Health Education
- DO: Dentist
- DM: Diabetes mellitus
- Dx: Diagnosis
- DDx: Differential diagnosis
- D: Distal
E
Ear, Nose & Throat
Electrocardiogram
Electroencephalogram
Endodontics
Epstein Barr Virus
Erythema Multiforma
Erythrocyte Sedimentation Rate
Examination
Exodontia

F
Family History/Social History
Fissure Sealant
Fluoride
Fracture
Full Blood Count
Full Gold Crown
Full Lower Denture
Full Upper and Lower Denture
Full Upper Denture

G
General Anaesthetic
General Dental Practitioner
General Medical Practitioner
Glass Ionomer Cement
Gutta Percha

H
Haemoglobin
Hepatitis
Herpes Simplex Virus
Herpes Varicella Zoster Virus
History
Hodgkin's Lymphoma
Hormone Replacement Therapy
Human Immunodeficiency Virus
Human Papilloma Virus

I
Immediate Denture
Intermediate Restorative Material
Impression
Incisal
Increased
Infection
Inferior Dental Nerve/Mandibular Nerve
Intermaxillary fixation
International Normalised Ratio
Intramuscular
Intraoral
Intravenous
Irrigation
<table>
<thead>
<tr>
<th>Letter</th>
<th>Term</th>
<th>Abbreviation</th>
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<tr>
<td>K</td>
<td>Kalsogen/Kalsogen/Kalzinogen</td>
<td>Kal</td>
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<td>L</td>
<td>Kaposi Sarcoma</td>
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<td>Lateral</td>
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<td>L</td>
<td>Left Hand Side</td>
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<td>Lymph Nodes</td>
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<td>Mandible/mandibular</td>
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</tr>
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<td>M</td>
<td>Maxilla/maxillary</td>
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<td>Medium Rhomboid Glossitis</td>
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<td>Motor Vehicle Accident</td>
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<td>Mouthguard</td>
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<td>Multiple sclerosis</td>
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<td>N</td>
<td>Negative</td>
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<tr>
<td>N</td>
<td>Next Visit</td>
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<td>N</td>
<td>No Abnormality Detected</td>
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<td>O/E</td>
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<td>Oral &amp; Maxillo Facial Surgery</td>
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<td>Ortho</td>
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<td>Orthopantomographic Radiograph</td>
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<td>P</td>
<td>Palatal</td>
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<td>P</td>
<td>Partial mandibular denture</td>
<td>-/P</td>
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<tr>
<td>P</td>
<td>Partial maxillary and mandibular dentures</td>
<td>P/P</td>
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<td>P/-</td>
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<td>Patient</td>
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<td>Periapical radiographs</td>
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<td>Permanent</td>
<td>Perm</td>
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<tr>
<td>P</td>
<td>Porcelain Fused to Metal Crown</td>
<td>PFM or VMK</td>
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<td>P</td>
<td>Post core</td>
<td>PC</td>
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<td>Posterior</td>
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<td>Prescribe/Treatment</td>
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<td>Preventive Resin Restoration</td>
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Primary
Prophylaxis  Prophy
Porcelain jacket crown  PJC
Prosthetics  Pros

R
Recurrent Aphthous Stomatitis  RAS
Refer  Ref
Relative Anaesthesia  RA
Relief of Pain  ROP
Reline  Rel
Repair  Rep
Right Hand Side  RHS
Root Canal Treatment  RCT
Root Planing  RP

S
Scale and Clean  S/C
Secondary  2°
Sjogren's syndrome  SjS
Sodium Fluoride  NaF
Squamous cell carcinoma  SCC
Stainless Steel  SS
Stannous Fluoride  SnF₂
Surgical Removal  S/R
Systemic Lupus Erythematous  SLE

T
Temperomandibular Joint  TMJ
Temperomandibular Joint Pain Dysfunction  TMPD
Temporary  Temp
Tender to Percussion  TTP
Treatment Plan  TP
Trigeminal Neuralgic  TN

Z
Zinc Oxide Eugenol  ZOE
Zinc Phosphate Cement  ZnP
Appendix C Federation Dentaire International Notation (FDI)

Methods of tooth notation have evolved over the years and there is now general global acceptance of the FDI system as the most appropriate system to provide maximum precision, clarity and compatibility with typing and computing requirements. It should be remembered that the only really safe method of recording teeth is to write a full description and this should be utilised along with the FDI notation if there is likely to be any confusion.

In FDI two-digit system of tooth numbering of the permanent and deciduous dentition the first number represents the quadrant starting at the right maxillary quadrant and working in a clockwise direction (1—4 for the permanent teeth and 5—8 for the deciduous teeth). The second digit identifies the tooth counting from the midline backwards. The tables gives the actual number for each tooth.

<table>
<thead>
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<th>Permanent Dentition</th>
<th>Maxillary right third molar</th>
<th>18</th>
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<tr>
<td>Maxillary right lateral incisor</td>
<td>52</td>
<td></td>
<td>Maxillary left lateral incisor</td>
<td>62</td>
</tr>
<tr>
<td>Maxillary right central incisor</td>
<td>51</td>
<td></td>
<td>Maxillary left central incisor</td>
<td>61</td>
</tr>
<tr>
<td>Mandibular right central incisor</td>
<td>81</td>
<td></td>
<td>Mandibular left central incisor</td>
<td>71</td>
</tr>
<tr>
<td>Mandibular right lateral incisor</td>
<td>82</td>
<td></td>
<td>Mandibular left lateral incisor</td>
<td>72</td>
</tr>
<tr>
<td>Mandibular right canine (cuspid)</td>
<td>83</td>
<td></td>
<td>Mandibular left canine (cuspid)</td>
<td>73</td>
</tr>
<tr>
<td>Mandibular right first molar</td>
<td>84</td>
<td></td>
<td>Mandibular left first molar</td>
<td>74</td>
</tr>
<tr>
<td>Mandibular right second molar</td>
<td>85</td>
<td></td>
<td>Mandibular left second molar</td>
<td>75</td>
</tr>
</tbody>
</table>
Appendix D  Examples of Appropriate Notes

Example 1. You perform a large filing on a deep carious lesion on the patient’s lower right first molar. The anaesthetic you used was 2.0 ml of lignocaine with adrenaline 1:80000. Because the lesion was deep radiographically, you mention to the patient that the tooth may lose vitality, and need endodontics or possibly extraction in the future. An appropriate clinical entry would be:

4/5/9 . 46MO Ca(OH)$_2$ GIC base/ AECR shade A3 Heliomolar 2.0 ml lig/adr 1:80000 IDN block . Deep lesion approaching pulp, patient advised may develop symptoms and require RCT or extraction.

Example 2. A patient presents with a decoronated maxillary lateral incisor. Its restorative prognosis is poor. You have discussed several options including a) endodontics, post core and crown b) extraction and denture c) extraction with bridge d) extraction with implant. Your clinical entry would need to include the discussion with your patient about the relative chance of success of each option, associated costs, advantages and disadvantages of each option, and any potential risks.

For example, your entry may read

4/5/9 Patient presents with decoronated 22. Minimal remaining tooth structure. Advised poor restorative prognosis. Discussed options as follows:
   a) endo, post core crown . Advised however guarded prognosis and high probability of root fracture. Costs $2000
   b) extraction and denture. Discussed limitations of dentures. Cost $1000 including casting fee
   c) extraction and replacement with bridge. Advised not ideal due to intact and unrestored abutments. Costs $4000+
   d) extraction and replacement with implant. Advised most ideal and durable option. Discussed time frames and Costs $8000--$12000 plus a fee to the surgeon.

A brief summary of your discussion of the advantages and disadvantages of each option as it relates to this particular patient is also appropriate.

Obviously, as the case complexity increases, so does the detail of note taking.

To illustrate the importance of adequate and comprehensive notes, assume your patient opted for option “a”, despite your preference in this situation for option “b” or “d”. You provide treatment to a high standard, but with little tooth structure remaining, the tooth root fractures vertically 6 months later. The patient presents unhappy, claiming your treatment failed prematurely. It is invaluable to then refer to your notes to see that you had outlined all options, made clear that option “a” had a guarded prognosis and that there were better alternatives. If, however, you refer to your notes, and these discussions are not recorded, there is no reliable evidence that such a conversation ever took place. This will make discussions with your patient more difficult. Further, should the patient decide to pursue the matter it will almost impossible to develop an adequate defence.
Appendix E  Prescription Writing

The following abbreviations are acceptable for use when prescribing medications:

- Before food: ac
- Twice a day: bd
- Gram: g or gm
- Intramuscular: im
- Intravenous: iv
- In the Morning: mane
- Milligram: mg
- Mixture: mist
- Millilitre: ml
- Nebuliser: neb
- At night: nocte
- Ointment: oint
- After food: pc
- When necessary: prn
- Every six hours: q6h
- Four times a day: qid
- Subcutaneous: s/c
- Immediately: stat
- Suppository: supp
- Suspension: susp
- Syrup: syr
- Three times per day: tds
- Topical: top

Any of the above may also be written out in full.

The following must be written in full:

- Chemical names
- Daily
- Ear or eye
- Lotion
- Microgram
- Oral
- Three times weekly and specify which days
- Twice weekly and specify which days
- Units

Decimal Points
When using decimal points for values of less than one, always place a zero before the decimal point, for example 0.5 ml.
Appendix F  Periodontal Screening and Recording Index (PSR)

The Periodontal Screening and Recording Index (PSR) is based on the CPITN (Community Periodontal Index of Treatment Needs) proposed by the WHO in the 1980’s. This index is used to ensure all patients have a periodontal record and if required, full periodontal examination. A simple grid is used to record the worst score per sextant, an asterisk (*) providing a cue that a sextant contains signs of previous or existing periodontics or requires more thorough investigation such as:

- Furcation involvement
- Recession > 3.5 mm
- Mobility
- Mucogingival problems

Note: In the Griffith patient management system asterisks cannot be placed in the recording boxes for the sextant so this information needs to be recorded in the accompanying notes section.

A code should be recorded for all sextants by probing as follows:

- 2 or more teeth per sextant
- Probing circumferentially around all teeth
- Recording only the worst score for each sextant
- Sextants with single teeth, if not scheduled for extraction, should be included in the adjacent sextant

The following table indicates the appropriate score for varying levels of pathology:

<table>
<thead>
<tr>
<th>Code</th>
<th>Periodontal status</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Healthy Periodotium (PD&lt;3.5mm)</td>
</tr>
<tr>
<td>1</td>
<td>Bleeding/Plaque Present (PD&lt;3.5 mm)</td>
</tr>
<tr>
<td>2</td>
<td>Calculus Detected (PD&lt;3.5 mm)</td>
</tr>
<tr>
<td>3</td>
<td>Probing depths 4-5 mm</td>
</tr>
<tr>
<td>4</td>
<td>Probing Depths ≥ 6 mm</td>
</tr>
</tbody>
</table>