**Standards for Clinical Record Cards**

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| **STANDARD** | **Red** | **Amber** | **Green** |
| **Patient Identifiers**  Patients first name and surname  Date of birth  Address  *Advisory :*  *Guardian details*  *Emergency contact details telephone number*  *GMP*  *Postcode* |  |  |  |
| **Medical History**  Signed by patient  Countersigned by dentist  Less than 12 months old or updated  Comprehensive medical history questionnaire  Yes/No responses to each question, with further details of points identified on questionnaire, including relevance and medication  **MH Update**  Verbally updated and recorded every new intervention.  new MHQ to be completed as appropriate, in line with practice protocol to be signed by patient and dentist |  |  |  |
| **Charting**  Full baseline charting of teeth and restorations  Charting of treatment proposed and provided  *Advisory:*  *Base line charting on each record card* |  |  |  |
| **BPE**  Record initially and update annually or next recall, whichever is the longer  Not necessary to record for; urgent treatments, patients with full dentures, children under 13 years |  |  |  |
| **Soft tissues**  Extra oral  TMJ  Lymph nodes  Intraoral  To be recorded for all ages at every examination (including urgent), to include both positive and negative findings |  |  |  |

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| **STANDARD** | **Red** | **Amber** | **Green** |
| **Patient information PDH/SH**  Smoking  Alcohol  PDH  If smoker cessation advice given  Fluoride use  Patient motivation  Anxiety  *Advisory :*  *Behavioural, diet, family history of gum disease, and to update smoking and alcohol /tobacco product intake to be recorded with each new medical history questionnaire in line with practice protocols.* |  |  |  |
| **Symptoms/ Reason for attendance**  If in pain full history  Record positive and negative findings |  |  |  |
| **Observations** |  |  |  |
| **Investigations** |  |  |  |
| **Radiographs**  In line with FGDP guidelines  Justified  Evaluated  Reported on  DPA opinion on quality |  |  |  |
| **Differential Diagnosis/es**  To be recorded |  |  |  |
| **Treatment planning**  Discussion of options/Risks recorded  Definitive Treatment plan  Schedule of treatment to be provided and sequenced – NHS and Private  FP17DC to be provided in accordance with the Regulations. |  |  |  |
| **Patient consent**  **Informed/Valid on basis of above discussions**  To record ‘Patient elected to have’ or ‘Verbal consent obtained for’ at each appointment |  |  |  |
| **Treatment provided**  To record details of; treatment provided, LA if used (which, quantity and site), tooth notation, materials used, post operative instructions given  ***Advisory :***  *To record batch numbers of local anaesthetics and materials used.* |  |  |  |
| **Prescriptions (a)**  Record medication, quantity, dosage and frequency |  |  |  |
| **Prescriptions (b)**  To record clinical justification |  |  |  |
| **Recall interval**  Recall interval to be recorded using NICE guidelines |  |  |  |

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| **STANDARD** |  |  |  |
| **General Admin FP 17 PR**  To be completed in line with Regulations.  Provider’s stamp, patient’s name and DOB, exemption status/category, signed, parts A and B correctly completed, part C completed if treatment complete.  For every course of treatment |  |  |  |
| **Band charges**  To record band and patient charge |  |  |  |
| **FP17DC**  To be completed in line with Regulations or to use an equivalent form approved by the PCT |  |  |  |

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| **STANDARD** | **Red** | **Amber** | **Green** |
| **Laboratory**  Scanned copy of docket acceptable  Should be kept for all new appliances provided, not necessarily in clinical notes, for as long as clinical records retained  Lab docket not required for all repairs |  |  |  |
| **All correspondence such as referrals**  Evidence of referral recorded in notes |  |  |  |
| **All entries**  To be dated and clearly identify operator |  |  |  |