

## Assessment of Treatment Needs

Primary responsibility: Clinician/Surgeon

Timing: At recall visit

Location: Chairside

Patient/date:

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### Patient Symptoms

- ☐ Yes   ☐ No   Soreness, discomfort, and/or pain
- ☐ Yes   ☐ No   Bleeding and/or suppuration
- ☐ Yes   ☐ No   Implant and/or prosthesis mobility
- ☐ Yes   ☐ No   Swelling and/or recession
- ☐ Yes   ☐ No   Unsatisfying soft tissue esthetics
- ☐ Yes   ☐ No   Bad breath (halitosis)

### Clinical/radiographic observations

- ☐ Yes   ☐ No   Swelling and/or recession
- ☐ Yes   ☐ No   Inflammation, bleeding and/or suppuration
- ☐ Yes   ☐ No   Implant and/or prosthesis mobility
- ☐ Yes   ☐ No   Marginal bone loss
- ☐ Yes   ☐ No   Peri-implant radiolucency
- ☐ Yes   ☐ No   Parafunction
- ☐ Yes   ☐ No   Poor oral hygiene
- ☐ Yes   ☐ No   Bad breath (halitosis)

### Action needed

- ☐ Yes   ☐ No   Regular follow-up
- ☐ Yes   ☐ No   Special attention
- ☐ Yes   ☐ No   Treatment

This checklist shall not substitute appropriate medical verification prior to the intended procedure and shall be used as an additional informative tool only. FOR does not make any representation as to the accuracy, fitness or completeness of the checklist.