Clinical Pre-Treatment Consultation

Primary responsibility: Clinician/Surgeon
Timing: End of the pre-treatment consultation while patient is still present
Location: Consultation room and/or chairside

FOUNDATION FOR ORAL REHABILITATION

Medical history questionnaire taken and reviewed orally
☐ Yes ☐ Not Applicable

Intraoral examination performed
☐ Yes ☐ Not Applicable

Radiographic examination completed and radiographs in patient's file
☐ Yes ☐ Not Applicable

Access and visibility of operative site confirmed
☐ Yes ☐ Not Applicable

Direction of roots adjacent to the edentulous area(s) checked
☐ Yes ☐ Not Applicable

Alveolar nerve located
☐ Yes ☐ Not Applicable

Suitable implants and components identified
☐ Yes ☐ Not Applicable

Provisional restoration(s) planned and laboratory alerted
☐ Yes ☐ Not Applicable

Premedication prescribed
☐ Yes ☐ Not Applicable

Patient Name: ----------

Date: ----------

Primary Responsible: ----------

Comments: ----------

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.

Administrative Pre-Treatment Consultation

Primary responsibility: Nurse/Dental Assistant
Timing: After pre-treatment consultation before patient leaves
Location: Consultation room and/or front desk

FOR
FOUNDATION FOR ORAL REHABILITATION

Personal information in patient's file (incl. contact info)
☐ Yes ☐ Not Applicable

Informed consent form given to patient
☐ Yes ☐ Not Applicable

Pre-operative information (incl. treatment plan) given to patient
☐ Yes ☐ Not Applicable

Financial estimate given to patient
☐ Yes ☐ Not Applicable

Patient Name: _____

Date: _____

Primary Responsible: _____

Comments: _____

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Stock and Materials Control

Primary responsibility: Nurse/Dental Assistant
Timing: At least one week before surgery
Location: Stock room

FOR
FOUNDATION FOR ORAL REHABILITATION

Sterile disposable materials stock controlled (e.g. gloves, suture, covers, surgical scrub brushes, antiseptic soap, surgical outfit)

☐ Yes ☐ Not Applicable

Drills and implants available for case

☐ Yes ☐ Not Applicable

Abutments available for case

☐ Yes ☐ Not Applicable

Prosthetic components available for case

☐ Yes ☐ Not Applicable

Membranes and grafting material available for case

☐ Yes ☐ Not Applicable

Surgical guide received and disinfected

☐ Yes ☐ Not Applicable

Patient Name: ----------

Date: ----------

Primary Responsible: ----------

Comments: ----------

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OR Setup

Primary responsibility: Nurse/Dental Assistant
Timing: Morning of the surgery (beginning of the day)
Location: OR/Surgical Suite/Operatory
Comments: Refers to one room (not patient); only performed 1x per day

FOR
FOUNDATION FOR ORAL REHABILITATION

Resuscitation kit available and complete
☐ Yes ☐ Not Applicable

Filter for sterile water installed and functioning properly
☐ Yes ☐ Not Applicable

Enough surgical scrub brushes & antiseptic soap for all participants in surgery
☐ Yes ☐ Not Applicable

Vacuum functional
☐ Yes ☐ Not Applicable

Implant motor functional
☐ Yes ☐ Not Applicable

Surgical unit controlled
☐ Yes ☐ Not Applicable

Irrigation material and saline water available
☐ Yes ☐ Not Applicable

Surgical and implant kit(s) complete and sterilized
☐ Yes ☐ Not Applicable

Radiology equipment is functional
☐ Yes ☐ Not Applicable

Room Name: _____

Date: _____

Primary Responsible: _____

Comments: _____

Patient Pre-Operative Steps

Primary responsibility: Clinician/Surgeon or Nurse/Dental Assistant
Timing: Shortly before surgery
Location: Chairside in OR/Surgical Suite/Operatory

FOR
FOUNDATION FOR ORAL REHABILITATION

Signed informed consent form in patient's file
☐ Yes ☐ Not Applicable

Signed financial estimate in patient's file
☐ Yes ☐ Not Applicable

Premedication taken as prescribed
☐ Yes ☐ Not Applicable

Radiographs checked and put on display
☐ Yes ☐ Not Applicable

Nature of operation clearly indicated and double-checked with patient
☐ Yes ☐ Not Applicable

Tooth numbering verified with pre-treatment record and confirmed with patient
☐ Yes ☐ Not Applicable

Practitioner is aware the patient wears a removable denture
☐ Yes ☐ Not Applicable

Surgical guide is readily available and disinfected
☐ Yes ☐ Not Applicable

Special instrumentation is functioning and set up (e.g. Piezosurgery unit, osteosynthesis screws, biomaterials, etc.)
☐ Yes ☐ Not Applicable

Patient Name: ----------

Date: ----------

Primary Responsible: ----------

Comments: ----------

Clinical Post-Operative Steps

Primary responsibility: Clinician/Surgeon
Timing: Immediately after completion of surgery
Location: Chairside in OR/Surgical Suite/Operatory

FOR
FOUNDATION FOR ORAL REHABILITATION

No hemorrhaging present (all bleeding stopped)
☐ Yes ☐ Not Applicable

Sterile gauze pads are firmly in place
☐ Yes ☐ Not Applicable

All needles and surgical blades separated, counted and accounted for
☐ Yes ☐ Not Applicable

Blood-contaminated litter separated and adequately processed
☐ Yes ☐ Not Applicable

Removable denture returned to patient and adjusted
☐ Yes ☐ Not Applicable

Patient Name: ----------

Date: ----------

Primary Responsible: ----------

Comments: ----------

Administrative Post-Operative Steps

Primary responsibility: Nurse/Dental Assistant
Timing: After leaving OR
Location: Consultation room and/or front desk

FOR
FOUNDATION FOR ORAL REHABILITATION

Analgesics provided/prescribed (confirmed with escort)

☐ Yes ☐ Not Applicable

Extra gauze pads provided

☐ Yes ☐ Not Applicable

Postoperative information provided, incl. after hours phone numbers (confirmed with escort)

☐ Yes ☐ Not Applicable

Operative report in patient's file

☐ Yes ☐ Not Applicable

Patient Name: _____

Date: _____

Primary Responsible: _____

Comments: _____

Close OR

Primary responsibility: Nurse/Dental Assistant
Timing: End of the day
Location: OR/Surgical Suite/Operatory
Comments: Refers to one room (not patient); only performed 1x per day

FOR
FOUNDATION FOR ORAL REHABILITATION

Disposable stock replenished and necessary material orders placed
☐ Yes ☐ Not Applicable

Material ready for sterilization
☐ Yes ☐ Not Applicable

Vacuum bag removed
☐ Yes ☐ Not Applicable

Room cleaned and materials stored away
☐ Yes ☐ Not Applicable

Room Name: ----------

Date: ----------

Primary Responsible: ----------

Comments: ----------

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