

Reviewed and revised December 2015.

Documents shown as *underlined italic text* in this document are available from the *Information for Registered Residents* web page.

The Oral-Dental Record Forms (“dental charts”) used by pre-2014 Alternate Pathway trainees and by 2014 Part-time Residents for canine patients and feline patients must be reviewed and approved by the Credentials Committee.

Submission during the first year of the training program is required for residents whose training program was registered on or after January 1st 2013.

Review will be via the *Pre-Approval* process.

Note: Approval of Dental Charts is not required if the resident is a full-time resident registered in an AVDC-approved residency site, because review of dental charts is included in the Residency Site review and approval process.

Format and Content:

1. A dental chart must be completed for all cases logged.
2. Examples of dental charts used by AVDC Diplomates are shown below. No chart is perfect for all patients. Develop a format that works for you, and have your Supervisor review it.
3. Abbreviated charts such as DentaLabels® are not sufficiently detailed for AVDC case-log purposes.
4. Use of AVDC abbreviations in dental charts is encouraged. If you use additional abbreviations that are not included in the *AVDC Abbreviation List*, provide definitions of your abbreviations on a cover page.
5. A dental chart is to include a place to record periodontal scoring information for individual teeth.

The examples currently available on the AVDC web site are currently under review by the Credentials Committee.

Submission:

Submit the files electronically via DMS as a Dental Charts document. If the charts are used clinically in printed format and electronic versions of the charts are not available, scan or photograph the charts to create images for electronic submission.

Name the files: ***YourLASTNAME,FirstName Dental Chart Dog or Cat or Horse***

Remember to complete the [Dental Chart Submission Form](#) and to upload it to the Specialty Hours document before submitting the document – the document will not be reviewed if this form is not attached to the DMS document. The blank [Submission Form](#) is available via a link in the Information for Registered Residents web page and via a link above the wide blue line in the Specialty Hours document.

Examples of Dental Charts

The example charts shown below are provided courtesy of several AVDC Diplomates.

CANINE RECORD

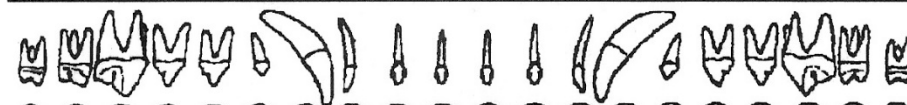
DATE _____ OWNER _____ ADDRESS _____
 OFF. TEL# _____ RES. TEL# _____ REFER VET _____ TEL.# _____
 CASE# _____ NAME _____ BREED _____ AGE _____ SEX _____
 CHIEF COMPLAINT _____ WT. _____

OCCLUSION ENDODONTICS ORTHODONTICS PROPHYLAXIS
 SKULL TYPE EXODONTIA PERIODONTAL SURGERY RADIOLOGY
 SALIVARY FLOW ORAL SURGERY RESTORATIONS
 TEMPOROMANDIBULAR PALPATION

110 109 108 107 106 105 104 103 102 101 201 202 203 204 205 206 207 208 209 210

Mobility/Furcation
 Perio Pocket
 Attachment Loss
 PDI

Buccal/Labial



MAXILLA



Right



Palatal

Buccal/Labial



MANDIBLE



Right



Lingual

411 410 409 408 407 406 405 404 403 402 401 301 302 303 304 305 306 307 308 309 310 311

Mobility/Furcation
 Perio Pocket
 Attachment Loss
 PDI

X-Ray Results _____
 Assessment _____
 Medication _____
 Feeding Instructions _____
 Special Instructions _____
 Re-Checks _____

Dear Doctor,

hart We thank you for this interesting referral and hope that we have been helpful. If you have any questions, or we can be of any further assistance, please don't hesitate to phone us.

KEY



- E External root resorptive lesion
- C Caries
- Missing
-) Pocket (list depth in mm)
- Fractured crown

CANINE ORAL EXAMINATION RECORD

[Note teeth and grade (if applicable).]

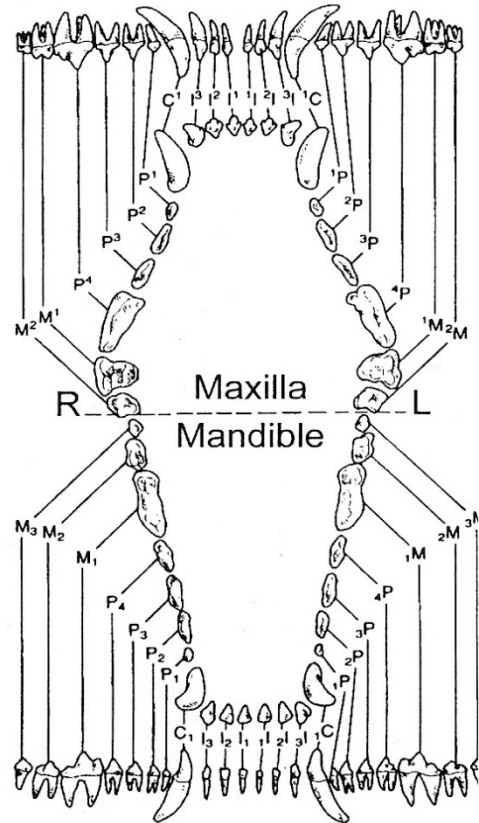
- General Comments
 - Saliva
 - Breath
 - Tonsils
 - Lips
 - Regional Lymph Nodes
- SKULL TYPE
 - ☐ Brachycephalic
 - ☐ Mesocephalic
 - ☐ Dolichocephalic
- OCCLUSION
 - ☐ Normal (scissors) bite
 - ☐ Level bite
 - ☐ Prognathic
 - ☐ Brachygnathic
 - ☐ Anterior crossbite
 - ☐ Posterior crossbite
 - ☐ Wry mouth
 - ☐ Attrition/Abrasion
- GINGIVA-PERIODONTAL DISEASE
(Grading* see back of first sheet)
 - ☐ None
 - ☐ Hyperplasia
 - ☐ Gingivitis*
 - ☐ Plaque*
 - ☐ Calculus*
 - ☐ Pockets > 3mm
 - ☐ Pockets > 5mm
 - ☐ Recession/root exposure
 - ☐ Furcation exposure*
 - ☐ Mobility*
- DENTAL ABNORMALITIES
 - ☐ Retained deciduous
 - ☐ Crowding
 - ☐ Rotation
 - ☐ Malpositioned teeth
 - ☐ Missing teeth
 - ☐ Supernumerary teeth
 - ☐ Fractures
 - ☐ Pulp exposure
 - ☐ External root resorptive lesion
 - ☐ Caries
 - ☐ Pulp hemorrhage

Date _____ Case Number _____

-  Crown
-  Restoration
- Furcation exposure
 - V Class I
 - Δ Class II
 - ▲ Class III

AL = attachment l

PE = pulp exposu



• RADIOGRAPHIC FINDINGS

**Page one of a two-page
Canine chart
Examination**

KEY

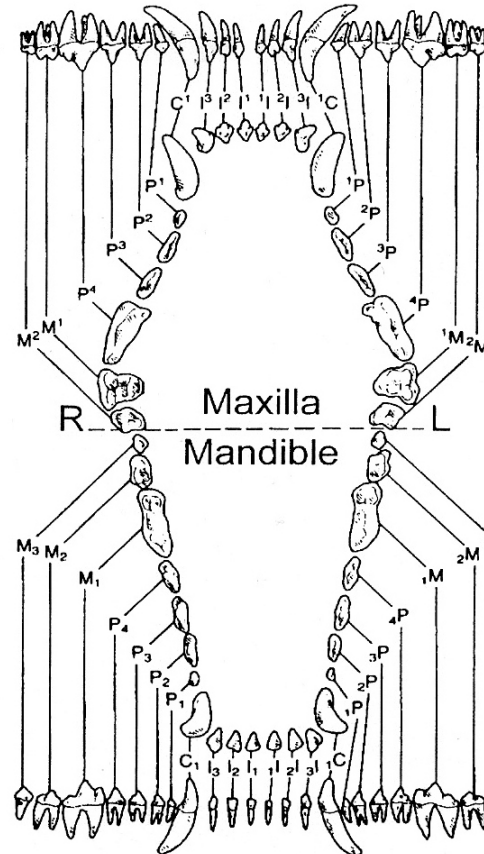
GV-Gingivectomy
FT-Fluoride Treatment
V-Varnish
× - Extraction
● - Missing
P - Pulpotomy
CR- Conventional root canal therapy

Date _____ Case Number _____

SR - Surgical root canal therapy
B - Bracket/button Ch - Chain E
G - Restoration-glass ionomer
C - Restoration-composite
A - Restoration-amalgam
/// - Crown

CANINE DENTAL TREATMENT

- ☐ RADIOLOGY
- PERIODONTICS
 - ☐ Ultrasonic scaling
 - ☐ Subgingival curettage/root planing
 - ☐ Polishing
 - ☐ Gingivectomy
 - ☐ Flap
 - ☐ Fluoride treatment
 - ☐ Varnish
- ORAL SURGERY
 - ☐ Exodontia
 - ☐ Routine extraction
 - ☐ Sectioning
 - ☐ Buccal cortical bone removal
 - ☐ Mucoperiosteal flap
 - ☐ Oronasal fistula repair
 - ☐ Gingival biopsy
 - ☐ Tumor removal
 - ☐ Mandible fracture repair
 - ☐ Other
- ENDODONTICS
 - ☐ Vital Pulpotomy
 - ☐ Conventional root canal
 - ☐ Surgical root canal therapy
 - ☐ Other
- RESTORATIONS
 - ☐ Amalgam
 - ☐ Composite
 - ☐ Glass ionomer
 - ☐ Crown
 - ☐ Flap
 - ☐ Crown Lengthening
- ORTHODONTICS
 - ☐ Impression/model
 - ☐ Bracket/button, elastics/chain
 - ☐ Acrylic splint
 - ☐ Incline plane
 - ☐ Other



- PERIOPERATIVE THERAPY
 - ☐ Antibiotic-Name-Dosage-Route
 1. Pre-op
 2. Post-op
 - ☐ Chlorhexidine
 - ☐ Local/Regional Anesthesia
 - ☐ Other
- OTHER PROCEDURES

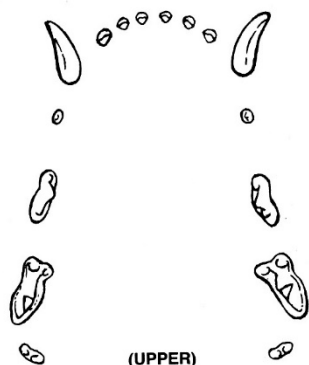
OWNER _____ PET _____ AGE _____ SEX _____

Breed _____ Color _____ Referred by _____ Date _____

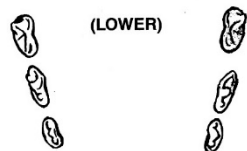
OCCLUSAL VIEW

FELINE DENTAL RECORD
TREATMENT

BUCCAL VIEW



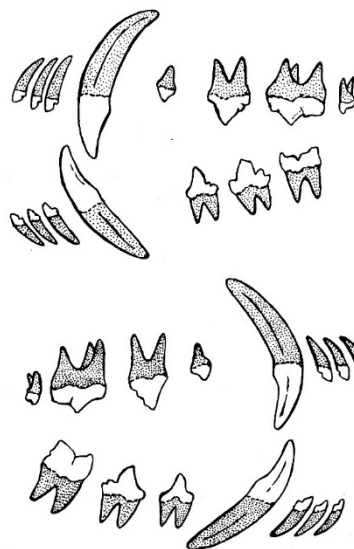
(UPPER)



(LOWER)

RIGHT

LEFT



LEFT

RIGHT

CODE KEY

A - Alveoloplasty
AP - Apicoectomy
BR - Bridge
CN - Crown (Cap)
CR - Crown Reduction
E - Electrosurgery
X - Extraction
FA - Filling (Amalgam)
FG - Filling (Composite)

FG - Filling (Glass Ionomer)
FP - Filling (Photo Cure)
FL - Flap Surgery
FT - Fractured Tooth Repair
G - Gingivectomy
GP - Gingivoplasty
H - Hemisection
L - Laser Treatment
M - Missing Tooth

N - Neck Lesion
O - Odontoplasty
OR - Orthodontics
PC - Pulp Capping
P - Pulpotomy
R - Restoration
RA - Root Amputation
RC - Root Canal
WI - Wiring

ANESTHESIA/SEDATION

- ☐ Acepromazine
- ☐ Ketamine _____ ml.
- ☐ Valium _____ ml.
- ☐ Gas Induction
- ☐ Isoflurane
- ☐ Other _____

ENDODONTICS

- ☐ Apicoectomy
- ☐ Pulp Capping (Direct)
- ☐ Pulpotomy (Vital)
- ☐ Root Canal (Single/Double/Triple)
- ☐ AH-26

- ☐ Calcium Hydroxide
- ☐ Gutta Percha (Points)
- ☐ GP (Thermoplastic)
- ☐ GP (Thermafil)
- ☐ Zinc Oxide/Eugenol
- ☐ Other _____

EXODONTICS

- ☐ Alveoloplasty
- ☐ Crown Reduction
- ☐ Extraction (Deciduous)
- ☐ Extraction (Root Remnant)
- ☐ Extraction
- ☐ Flap Surgery (Gum)

- ☐ Hemisection/Section
- ☐ Odontoplasty
- ☐ Osteoplasty
- ☐ Osteotomy
- ☐ Root Amputation
- ☐ Sutures (Abs./Non /

ORTHODONTICS

- ☐ Acrylic (Device)
- ☐ Braces
- ☐ Brackets
- ☐ Elastic Device
- ☐ Expansion Device
- ☐ Impression/Stone Model

- ☐ Inclined Plane
- ☐ Maryland Bridge
- ☐ Orthodontic Device
- ☐ Splinting
- ☐ Retainers
- ☐ Wiring

PERIODONTAL SURGERY

- ☐ Biopsy (Bone/Tissue)
- ☐ Culture/Sensitivity
- ☐ Curettage (Open)
- ☐ Flap (Double Reverse / Open / Reposition / Sliding)
- ☐ Guided Tissue Regeneration
- ☐ Gingivectomy/Gingivoplasty
- ☐ Graft (Gingiva / Bone)
- ☐ Implant
- ☐ Radio (Electro) Surgery
- ☐ Splinting (Periodontal)
- ☐ Sutures (Abs./Non Abs.)

X-RAYS

- ☐ Head
- ☐ Mandible
- ☐ Maxilla
- ☐ Occlusal
- ☐ Periapical
- ☐ Total No. _____

PROPHYLAXIS

- ☐ Curettage (Subgingival)
- ☐ Exploration
- ☐ Fluoride Treatment
- ☐ Hand Scaling
- ☐ Polishing
- ☐ Root Planing
- ☐ Roto-Pro
- ☐ Ultrasonic/Sonic
- ☐ Varnish (Sealing)

RESTORATIONS

- ☐ Bridge
- ☐ Core Build-up
- ☐ Crown (Cap)
- ☐ Crown Lengthening
- ☐ Crown Preparation
- ☐ Fillings:
 - ☐ Amalgam
 - ☐ Composite
 - ☐ Glass Ionomer

- ☐ Fractured Tooth Repair
- ☐ Impression/Stone Model
- ☐ Odontoplasty
- ☐ Pins
- ☐ Pit/Fissure Sealing
- ☐ Post
- ☐ Pulp Capping (Indirect)
- ☐ Veneer
- ☐ Other _____

SURGERY - ORAL

- ☐ Epulis Removal
- ☐ Fistula Repair
- ☐ Fracture Repair (Bone)
- ☐ Frenectomy/Frenotomy
- ☐ Laser Treatment
- ☐ Mandibulectomy
- ☐ Maxillectomy
- ☐ Osteotomy
- ☐ Papilloma Removal

- ☐ Pins/Plates
- ☐ Reimplant Tooth
- ☐ Splint (Acrylic)
- ☐ Splinting (Interdent)
- ☐ Sutures (Abs./Non /
- ☐ Tumor Removal
- ☐ Wiring (Interdental)
- ☐ Wiring (Interosseus)
- ☐ Other _____

Comments _____

X-Ray Results _____

Feeding Instructions: _____

Special Instructions: _____

Medication: _____ Rechecks: _____

Page 1 of a two-page Feline chart

FELINE DENTAL FORM		MEDICAL ALERT																																	
Owner _____ Pet Name _____ Date ____/____/____ DOB ____/____/____ Sex: M NM Fe SF Species: _____ Breed: _____ Chief Complaint _____ Past Dental History _____ Last Prophylaxis ____/____/____ Pertinent Medical History _____ Diet _____ Chew Toys _____ Home Dental Care: Brush _____ Rinse _____ Meds _____ Other _____ Other _____ Case # _____ MRCL cross Reference# _____																																			
INITIAL EXAM																																			
SKULL TYPE Brachycephalic _____ Mesocephalic _____ Dolichocephalic _____ Other: _____	DENTAL ABNORMALITIES Ret. Deciduous _____ Missing _____ Supernumerary _____ Caries _____ Broken _____ Discolored _____ Gingival recession _____ Gingival hyperplasia _____ Tooth mobility _____ Furcation exposure _____ Other _____	INDEXES Overall calculus index (CI): (0) None (I) Supragingival w/ sl. subging. (II) Moderate subgingival (III) Abundant supra and/or Subging. Overall Gingivitis Index (GI): (0) None (I) mild/ no bleeding (II) moderate/ bleeding on probing (III) severe/ spontaneous bleeding MISC. Oral Enlargements _____ Pharynx _____ TMJ _____ Other _____																																	
OCCLUSION Normal Scissors Class I: PM Shift _____ Anterior Crossbite _____ Posterior Crossbite _____ Rostrally deviated Max. Canine _____ Base narrow lower canines _____ Class II: (Brachygnathic/Over) _____ Class III: (Prognathic/Under) _____ Level/ reverse scissor/underbite _____ Other: Wry _____ Occlusal wear: I C P M	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 50%; text-align: center; padding: 5px;">PRE-ANESTHETIC EXAM</th> <th style="width: 50%; text-align: center; padding: 5px;">MEDICATIONS</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;"> Auscultation _____ MM/CRT _____ Weight (Kg) _____ </td> <td style="padding: 5px;"> Fluids: Type / route / volume _____ _____ _____ </td> </tr> <tr> <td style="padding: 5px; vertical-align: top;"> ANESTHESIA <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%; text-align: center; padding: 5px;">Agent</th> <th style="width: 40%; text-align: center; padding: 5px;">Dose (mg) / route</th> <th style="width: 30%; text-align: center; padding: 5px;">Time</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">PA</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">_____</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">_____</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">_____</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">Induc.</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">Maint.</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">E.T. tube size: _____</td> <td style="padding: 5px;">Time Finished: _____</td> <td></td> </tr> <tr> <td style="padding: 5px;">Pulse Ox Reading: _____</td> <td style="padding: 5px;">Doppler Pressure: _____</td> <td></td> </tr> </tbody> </table> </td> <td style="padding: 5px; vertical-align: top;"> Meds administered: _____ _____ Meds dispensed: _____ _____ Recommended Followup: _____ _____ </td> </tr> </tbody> </table>		PRE-ANESTHETIC EXAM	MEDICATIONS	Auscultation _____ MM/CRT _____ Weight (Kg) _____	Fluids: Type / route / volume _____ _____ _____	ANESTHESIA <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%; text-align: center; padding: 5px;">Agent</th> <th style="width: 40%; text-align: center; padding: 5px;">Dose (mg) / route</th> <th style="width: 30%; text-align: center; padding: 5px;">Time</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">PA</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">_____</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">_____</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">_____</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">Induc.</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">Maint.</td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">E.T. tube size: _____</td> <td style="padding: 5px;">Time Finished: _____</td> <td></td> </tr> <tr> <td style="padding: 5px;">Pulse Ox Reading: _____</td> <td style="padding: 5px;">Doppler Pressure: _____</td> <td></td> </tr> </tbody> </table>	Agent	Dose (mg) / route	Time	PA			_____			_____			_____			Induc.			Maint.			E.T. tube size: _____	Time Finished: _____		Pulse Ox Reading: _____	Doppler Pressure: _____		Meds administered: _____ _____ Meds dispensed: _____ _____ Recommended Followup: _____ _____
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Pulse Ox Reading: _____	Doppler Pressure: _____																																		
Referred by: _____ Contact # _____ Contact made on ____/____/____ at ____ AM PM Spoke with _____ Referral Letter sent on ____/____/____ To _____ Documentation: Rads / Polaroid Photos / Digital Photos _____ Misc. Notes: _____																																			

FELINE ORAL DIAGNOSIS, TREATMENT PLAN, AND DENTAL TREATMENT CHART

	M1 109	P4 108	P3 107	P2 106	C1 104	I3 103	I2 102	I1 101	I1 201	I2 202	I3 203	C1 204	P2 206	P3 207	P4 208	M1 209	
DX																	DX
PLAN																	PLAN
TX																	TX

RIGHT
SIDE

Buccal

Occlusal

Palatal

Lingual

Occlusal

Buccal

LEFT
SIDE

Buccal

Occlusal

Palatal

Lingual

Occlusal

Buccal

DX																	DX
PLAN																	PLAN
TX																	TX

M1
409

P4
408

P3
407

C1
404

I3
403

I2
402

I1
401

I1
301

I2
302

I3
303

C1
304

P3
307

P4
308

M1
309

General Remarks: _____

Radiographic Evaluation/Assessment: _____

Treatment Summary and Plan: _____
