Rationale: The case documentation paper is an assessment measurement tool that is required to be completed as part of the clinical requirements for graduation. Students must obtain a score of “Competent” or they will need to write the paper until it is acceptable. The paper is due within three (3) weeks of patient completion in the clinic. Failure to turn in the paper on time will result in the student having to complete another case documentation on a different patient. The case documentation paper needs to be typed and double-spaced. The report should be written so that the reader does not have to refer to the clinic forms to obtain the facts of the case.

Client Requirement: In most cases this will be a class III and/or class IV new patient that presents to the dental hygiene clinic. The goal is to be able to observe changes in the soft tissue in the photographs. In the event the client is a class IV patient, only one student may submit the case for case documentation credit.

Report Information: At a minimum the following items should be included: The case example format is to be followed, but information contained includes all of the following:

I. DENTAL HYGIENE ASSESSMENT & SUMMARY - include the following
   Patient Profile
   Chief Complaint
   Past Dental History
   Medical History Summary
   Review of Systems
     HEENT
     Skin
     CV
     Resp
     GI
     GU
     Hemo
     Endo
     CNS
   Clinical Findings
     Extraoral examination
     Intraoral examination
     Radiographic findings
     Periodontal examination – be sure to include before and after pocket depths in two quadrants as shown in the article

   Also, summarize the findings of the above mentioned information that was obtained in a paragraph and relate the clinical findings with the radiographic findings.
II. DENTAL HYGIENE DIAGNOSIS - discuss the:
- Rationale for case selection
- Rationale for case classification and periodontal typing
- Dental Hygiene Diagnosis & Goals

III. PLANNING - discuss the:
- Special Considerations - discuss special modifications that may have to be taken into account with this patient; i.e. physical handicap, comprehension; dry mouth, etc.
- Initial Treatment Plan - list out the initial treatment plan proposed broken down into appointments and units of time as well as specific home care instructions.

IV. IMPLEMENTATION - discuss the:
- Procedures performed each appointment
- Dental health education prescribed
- Discuss the changes seen at each appointment and any modifications in treatment you made because of what you saw or difficulties that arose

V. EVALUATION - discuss
- How you determined the endpoint of treatment; did you see changes in any objective measurement tools such as bleeding index, plaque score, tissue tone, etc.
- Did you reach each goal you set out to do and how do you know?
- What did you learn from this case?
- What would you have done differently?

VI. RECALL PLAN - discuss
- Based upon your evaluation, what recommendations do you have going forward for this patient? - referral, recall time, etc.

VII. APPENDICES: Include in the report a copy of:
A. Completed and signed DHY 21/220/230 grading form
B. WCCCD treatment record notations
C. Entire medical record including:
   - health history
   - intra/extraoral examination
   - consent forms
   - periodontal charting
   - restorative charting
   - BUP
   - plaque indices
   - referral form
   - pathology form
   - radiographic evaluation form
   - case presentation assessment form
   - informed consent form
   - treatment record
D. A duplicated copy of the radiographs of diagnostic quality
E. Pre-, mid-, and final digital photographs (undisclosed & disclosed) with dates taken of three different areas in the mouth; one view is to be the direct facial, one view is to be either the anterior maxillary or mandibular lingual, and the third view is your choice; i.e. 6 photos per appointment (3 disclosed and 3 undisclosed); Note - in order for the mid photo’s to show a change in tissue tone, the student must scale that side of the mouth first.

F. Four photo’s of a completed set of study models that were taken prior to the initiation of treatment. Show the facial, right and left views and either an occlusal or lingual view of student’s choice. Place the models against a black piece of paper or bib cover.
WAYNE COUNTY COMMUNITY COLLEGE DISTRICT

DENTAL HYGIENE CLINICAL PROCEDURES
FOR
CASE DOCUMENTATION

Student Name__________________________________________

Patient Name__________________________________________ Classification__________________ AAP Type __________

CASE DOCUMENTATION
1. Instructor approval obtain Accept/Unacc ____________________________

Faculty Signature & Date

2. Intraoral Photographs taken
   a. Initial ________________
   b. Mid ________________
   c. Final ________________

Faculty Signature & Date

3. Study Models complete
   a. Impressions ________________
   b. Pour-up ________________
   c. Final ________________

Faculty Signature & Date

4. FMX duplicated, acceptable ________________

Faculty Signature & Date

5. Preliminary paper completed ________________

Faculty Signature & Date

* Prior to starting the second quadrant of scaling, the student must show the clinical instructor a typed draft of the final report including Sections I – III. DH Assessment & Summary, Dental Hygiene Diagnosis, and Planning Phase and the duplicated radiographs.

Instructor Feedback: Clinical Instruction - Please provide any pertinent observations you discussed with the student on the back of this form.
Wayne County Community College District
Dental Hygiene Program
Primary Trait Scale
Case Documentation
Submitted in DHY 210/220/230

Assignment:

Prepare a case documentation study using criteria from written materials, lectures and clinical reports. All patient identifying information must be BLACKED out before leaving the clinic.

Trait Overall Presentation

5 - The student will provide the following in the written and visual report which includes:

A written report which includes ALL information outlined in each of the following categories that was outlined on the Case Documentation Instructions.

A. Dental Hygiene Assessment & Summary – refer to instructions
B. Dental Hygiene Diagnosis
   1) rationale for case selection
   2) rationale for case classification and periodontal typing
   3) goals
C. Planning
   1) special considerations
   2) initial treatment plan
D. Implementation
   1) dental health education prescribed
   2) changes and modifications made
   3) treatment performed
E. Evaluation
   1) discuss how the endpoint of treatment was determined
   2) were the goals set reached and if not, why?
F. Recall Plan
G. A cover page with student name, course name, date and name of project submitted
H. Appendices which includes:
   1) A quality duplicated copy of the client’s full mouth series of radiographs, mounted that is an acceptable and graded survey with retakes completed
   2) Quality photographs of study models that have been graded for taking of impressions, pouring, and trimming showing 4 views - facial, right side, left side, and one occlusal or lingual view of student’s choice.
   3) Quality intra-oral slides/photographs from 3 appointments comprising a total of 18 pictures. These should be taken at the beginning of treatment, after
healing on the first two quads (midpoint), and after final scaling taking them after scaling and polishing.

4) Clinical chartings to include dental, periodontal, bleeding upon probing and plaque scores.
5) Medical and dental history form with all consents signed.
6) Treatment records with appropriate signatures and treatment provided.

I. Appropriate format, grammar and spelling were followed
J. Submitted within 1 month of completion of clinical treatment
K. Patient confidentiality was maintained

4 The report is lacking in ONE of the areas above (A - J)
3 The report is lacking in TWO or THREE of the areas above
2 The report is lacking in FOUR to FIVE of the areas described above
1 The report is lacking in SIX to EIGHT of the areas described above.

Grade conversion: 4-5 points acceptable/competent
0 – 3 points = must be redone

Student Name:_______________________________
Date:______________________________________
Points:_____________________________________
Faculty Signature:____________________________