Dental Hygiene Progress Form

Candidate Sequential:____

CandidateID:____

PLACE ID LABEL HERE

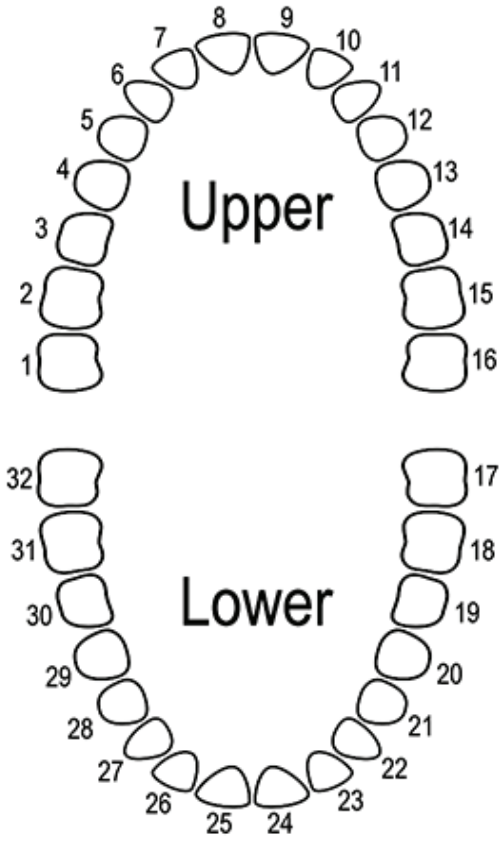
Test Site:____

Cubicle #:

Patient Name:_____

Please indicate the following on the chart below:

X = missing teeth
O = unerupted and partially erupted teeth
IMPL. = implant



CASE SELECTION

Circle quadrant:

UR UL

LR LL

Posterior teeth in 2nd quadrant:

#_____ #_____

Include primary quadrant's 3rd molar?

Yes No

CANDIDATE'S NOTES and COMMENTS TO EXAMINER:

Candidate: **Number each comment**
Examiner: **Place your examiner number and time noted after each comment**

	Examiner 1	Examiner 2	Examiner 3
Comments Reviewed on pre-treatment			
Comments Reviewed on post-treatment			

QUALIFYING CALCULUS DETECTION FINDINGS:

To be completed before starting treatment

On the Candidate Findings Form, indicate if qualifying calculus is present for each of the four indicated surfaces on each assigned tooth.

Tooth #	Tooth #	Tooth #	Tooth #

PROBING MEASUREMENT ASSIGNMENTS:

To be completed post- treatment

On the Candidate Findings Form, measure and record the depth of each sulcus/pocket on these assigned teeth.

Anterior Tooth #	Posterior Tooth #

Finish Time: _____

Is this patient being shared with another candidate today? YES ☐ NO ☐

If so, enter the candidate's number: ☐☐☐

Inject. Local Anes.

PATIENT CONSENT FORM

Approved by CFE **Examiner** #:	☐☐☐☐☐

MEDICAL HISTORY AND BLOOD PRESSURE

Approved by CFE **Examiner** #:	☐☐☐☐☐

RADIOGRAPHS

Approved by CFE **Examiner** #:	☐☐☐☐☐

ANESTHETIC RECORD (actual use)

Non Injectable Local Anesthetic/Periodontal Gels (*Brand/Generic Name*):	
CFE Approval for Non Injectable Local Anesthetic/Periodontal Gels **Examiner #**:	☐☐☐☐☐

Injectable Anesthetic(s) *(Brand/Generic Name)*:	
Type(s) of Injection *(Infiltration/Block)*:	
Quantity of Anesthetic *(mg)* Expected to use:	mg
Vasoconstrictor *(Concentration):* Vasoconstrictor *(mg):*	mg
Has the patient previously rec'd anesthetic the same day? Anesthetic and Dose:	Yes No mg
CFE Approval for Initial Injectable Anesthetic **Examiner** #:	☐☐☐☐☐

Additional Anesthesia - Anesthetic and Dose**:**	mg
CFE Approval for Additional Injectable Anesthetic **Examiner** #:	☐☐☐☐☐

Number of Anesthetic Cartridges Actually Used?	_____ml each

Third Party Administration of Anesthetic: ***(approved locations only)***

_____
PRINT NAME

_____
SIGN NAME

PRE-TREATMENT MEDICATION (if required)

Medication(s) *(Brand/Generic Name)*	
Dosage/When Taken	