

# Dental Hygiene Progress Form

Candidate Sequential: \_\_\_\_\_

Candidate ID: **PLACE ID LABEL HERE**

Test Site: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Cubicle #:

Please indicate the following on the chart below:

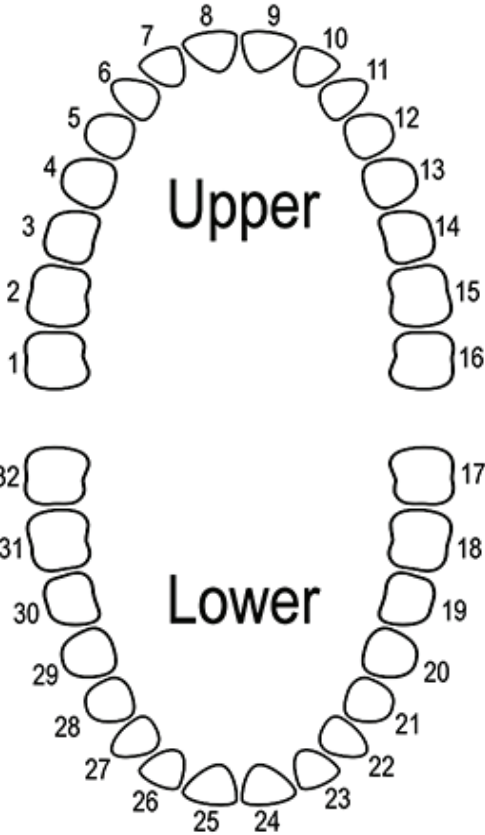
- X = missing teeth
- O = unerupted and partially erupted teeth
- IMPL. = implant

## CASE SELECTION

Circle quadrant:      Posterior teeth in 2nd quadrant:      Include primary quadrant's 3rd molar?  
 UR   UL                      # \_\_\_\_\_    # \_\_\_\_\_                      Yes    No  
 LR   LL

### CANDIDATE'S NOTES and COMMENTS TO EXAMINER:

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




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	Examiner 1	Examiner 2	Examiner 3
Comments reviewed on pre-treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Comments reviewed on post-treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### 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 #
<input type="text"/>	<input type="text"/>

### QUALIFYING CALCULUS DETECTION FINDINGS:

*To be completed before starting treatment*

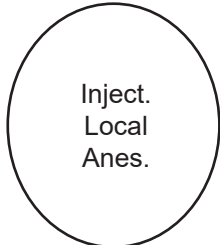
On the Candidate Findings Form, indicate if qualifying calculus is present for each of the four indicated surfaces on each assigned tooth.

Tooth #	Tooth #	Tooth #
<input type="text"/>	<input type="text"/>	<input type="text"/>

Finish Time:

Is this patient being shared with another candidate today?

YES NO



If so, enter the candidate's number:

**PATIENT CONSENT FORM**

Approved by CFE <b>Examiner #:</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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**MEDICAL HISTORY AND BLOOD PRESSURE**

Approved by CFE <b>Examiner #:</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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**RADIOGRAPHS**

Approved by CFE <b>Examiner #:</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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**ANESTHETIC RECORD (actual use)**

<b>Non Injectable Local Anesthetic/Periodontal Gels</b> <i>(Brand/Generic Name):</i>	
CFE Approval for Non Injectable Local Anesthetic/Periodontal Gels <b>Examiner #:</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

<b>Injectable Anesthetic(s)</b> <i>(Brand/Generic Name):</i>	
Type(s) of Injection <i>(Infiltration/Block):</i>	
Quantity of Anesthetic (mg) Expected to use:	_____ mg
Vasoconstrictor <i>(Concentration):</i> 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 <b>Examiner #:</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

<b>Additional Anesthesia - Anesthetic and Dose:</b>	_____ mg
CFE Approval for Additional Injectable Anesthetic <b>Examiner #:</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

<b>Number of Anesthetic Cartridges Actually Used?</b>	_____ ml each
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<b>Third Party Administration of Anesthetic:</b> <i>(approved locations only)</i>	_____ <i>PRINT NAME</i>
	_____ <i>SIGN NAME</i>

**PRE-TREATMENT MEDICATION (if required)**

Medication(s) <i>(Brand/Generic Name)</i>	
Dosage/When Taken	