Qualified Patient/Tooth/Lesion Treatment Form

Candidate Sequential:____

Candidate ID:

PLACE ID LABEL HERE

Test Site:____

Cubicle #: ☐

Patient Name:_____

Date radiograph was taken:_____

Tooth # ☐ **Circle the Surface(s) Planned:** Class III MF ML DF DL Class II MO DO MOD

Describe the other surfaces on the tooth to be treated that have diagnosed caries but are not scheduled to be treated for this exam and what the treatment plan is for each surface (circle applicable information):

Surface(s): Class III M F D L

Treatment Planned: remineralization therapy or restoration

Surface(s): Class II M B D L

Treatment Planned: remineralization therapy

The following criteria must also be met for the patient/tooth/lesion selection to be accepted for lesion approval evaluation:

- Patient is a patient of record at the dental school and is approved currently for this treatment
- Patient fulfills all patient selection requirements
- Tooth fulfills examination requirements
- Occlusion verified for posterior from examination's qualifying criteria
- Radiographs have been exposed within one year of the examination
- Proximal contact visually verified with clean and dry tooth
- Caries verified as qualifying from examination criteria
- For anterior teeth: defective restoration qualifies from examination's criteria
- Adjacent tooth: no cavitation and allows for restoration of ideal form
- For posterior tooth: all Class V lesions must be pre-treated before the exam

I, _____, verify that I have clinically evaluated the patient named on this form.
Faculty member (legibly print name)

Based on my examination, the patient/tooth/lesion that is identified here fulfills the examination's qualifying requirements and is acceptable for treatment during the CDCA-administered examination at this time.

Faculty member signature: _____ Date: _____