FIXED PROSTHODONTICS
STANDARDS OF CARE EVALUATION FORM

Resident's Name: _____
Patient's Name: _____

Month: _____ Procedure: _____

	Acceptable	Needs Impr.	Unacceptable
1. Patient's Medical & Dental History & Treatment Plan			
2. Diagnostic Casts			
3. Anesthesia			
4. Preparations			
5. Retraction			
6. Final Impressions			
7. Jaw Relation Records			
8. Provisional Restorations			
9. Laboratory Procedures			
a. Casts:			
i. Bubbles, dust, voids			
ii. Periphery trimmed			
iii. Positional record			
iv. Articulated casts			
v. Custom incisal guide			
b. Dies:			
i. Axial reduction			
ii. Occlusion reduction			
iii. Taper of Preparation			
iv. Trim of dies			
v. Margins marked			
vi. Stability of dies			
c. Laboratory Prescription:			
i. Patient data			
ii. Facial margin type			
iii. Special instructions			
10. Try-In:			
a. Margins			
b. Contours			
c. Contacts			
d. Occlusion			
e. Shade			
f. Characterization			
g. Polish			

11. Cementation _____ _____ _____
12. Patient Management _____ _____ _____
13. Time Management _____ _____ _____

Treatment Assessment

1. Acceptable_____
2. Needs Improvement _____
3. Unacceptable _____

Performance Standard Assessment

Resident: _____

Mentor: _____

Date: _____

COMMENTS: