IMPLANT 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. Treatment Plan	_____	_____	_____
4. Diagnostic Waxing/Surgical Guide	_____	_____	_____
5. Phase I:			
a. Post-Surgical Adjustments	_____	_____	_____
6. Phase II:			
a. Abutment Placement:	_____	_____	_____
b. Preliminary Impressions	_____	_____	_____
7. Final Impressions	_____	_____	_____
8. Record Bases	_____	_____	_____
9. Jaw Relation Records	_____	_____	_____
10. Wax Try-In			
a. Vertical Dimension	_____	_____	_____
b. Centric Relation	_____	_____	_____
c. Shade and Mold	_____	_____	_____
d. Anterior Arrangement	_____	_____	_____
e. Cantilever length	_____	_____	_____
11. Superstructure Try-In	_____	_____	_____
12. Insertion/Home Care Instr.	_____	_____	_____
13. Post Insertion/POT Protocol	_____	_____	_____
14. Laboratory Procedures	_____	_____	_____
a. Casts	_____	_____	_____
b. Record Bases	_____	_____	_____
c. Tooth Set-up	_____	_____	_____
d. Processed Prosthesis	_____	_____	_____
e. Finished Prosthesis	_____	_____	_____
f. Laboratory Prescription	_____	_____	_____
15. Patient Management	_____	_____	_____
16. Time Management	_____	_____	_____

Treatment Assessment

Acceptable: _____
Needs Improvement: _____
Unacceptable: _____

Performance Standard Assessment

Resident: _____
Mentor: _____
Date: _____

COMMENTS: