TEMPOROMANDIBULAR DISORDERS
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. Jaw Relation Records	_____	_____	_____
4. Laboratory Procedures:			
a. Casts:	_____	_____	_____
1. Bubbles, dust, voids	_____	_____	_____
2. Periphery trimmed	_____	_____	_____
3. Centric	_____	_____	_____
4. Casts articulated	_____	_____	_____
b. Laboratory Prescription:			
1. Patient data	_____	_____	_____
2. Materials	_____	_____	_____
3. Special instructions	_____	_____	_____
5. Occlusion			
a. Occlusal Plane	_____	_____	_____
b. Contours	_____	_____	_____
c. Contacts	_____	_____	_____
d. Occlusal Scheme	_____	_____	_____
e. Polish	_____	_____	_____
6. Delivery	_____	_____	_____
7. Follow-up	_____	_____	_____
8. Patient Management	_____	_____	_____
9. Time Management	_____	_____	_____

Treatment Assessment

Acceptable: _____
Needs Improvement: _____
Unacceptable: _____

Performance Standard Assessment

Resident: _____
Mentor: _____
Date: _____

COMMENTS: