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<tr><td rowspan="4"> ADMINISTRATIVE POLICIES AND PROCEDURES
State of Tennessee
Department of Correction</td><td>Index #: 113.60</td><td>Page 1 of 5</td></tr>
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<tr><td colspan="2" rowspan="2">Supersedes: 113.60 (7/1/19)
PCN 21-33 (12/30/21)
PCN 19-54 (8/9/19)</td></tr>
<tr><td>Approved by:</td></tr>
<tr><td colspan="3">Subject: DENTAL SERVICES ADMINISTRATION</td></tr>
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I. AUTHORITY: TCA 4-3-603 and TCA 4-3-606.

II. PURPOSE: To specify the responsibilities of the dental authority, to outline the range of dental services available to inmates (including intake dental screenings/examinations), to set guidelines in order to determine the dental classification system, and to identify treatment priorities.

III. APPLICATION: Wardens, Associate Wardens/Superintendents, Associate Wardens of Treatment/Deputy Superintendents, Health Administrators, Dentists, dental care staff, medical contractors, privately managed institutions, and inmates.

IV. DEFINITIONS:

A. Adequate Mastication: The ability to chew food, as evidenced by an occlusion score of 16 points or more.

B. Dental Authority: The licensed dentist responsible for dental care to inmates and the supervision of dental staff within the institution.

C. Occlusion Score: The meeting of two opposing tooth surfaces with the total of occlusion points scored as follows:

1. Wisdom teeth = 0 points
2. Occluding incisors or cuspids = 1 point, (i.e., #7 with #26 = 1 point)
3. Functioning Premolars = 2 points
4. Functional 1st or 2nd molars = 3 points, (i.e., #3 with #30 = 3 points)

V. POLICY: An initial dental examination shall be completed within 14 days of receipt into the physical custody of the Tennessee Department of Correction (TDOC). Inmates shall be provided routine and emergency dental care as part of the institutional health care program according to the priority of need.

VI. PROCEDURES:

A. Dental Staff:

1. The responsibilities of the dental authority shall include, but not be limited to:

a. Providing dental services in accordance with the Department's policies, OSHA standards, the American Dental Association's infection control guidelines, and regulations of the Tennessee Board of Dentistry.

b. Requesting dental specialty consultations for the appropriate care of the inmate, as needed.

c. Coordinating clinical schedules with the health administrator and institutional staff to ensure dental care delivery within the institution's security constraints.

d. Ensuring continuity of care to all inmates permanently transferred to the facility according to the priority of need.

2. The duties of dental assistants and dental hygienists shall be in accordance with the rules and regulations of the Tennessee Board of Dentistry. The dental authority shall supervise all dental staff's assignments, duties, and clinical training (if necessary).

B. Intake Dental Services: Dental services available through the diagnostic center shall include the following:

1. Intake Dental Questionnaire, CR-4203: This form shall be completed by facility dental staff during intake classification before the intake dental examination and filed in Section VI. of the health record.

2. Intake Dental Examination: Each inmate shall receive an examination by a dentist during intake classification, which shall include a Periodontal Screening and Recording (PSR) or a recognized periodontal health assessment. The examination shall consist of a pan-oral x-ray to aid in the detection of abnormalities and as needed, an intra-oral x-ray to aid in the detection of dental caries and other dental problems, which will assist in the development of the treatment plan established by the dentist. The treatment plan is established to inform the inmate of his/her oral condition at the time of intake.

3. Intake Dental Treatment: During intake classification, treatment shall be limited to dental care requiring immediate attention (Category I-II). If the inmate becomes permanently assigned to a diagnostic center, any needed dental prosthetics, as indicated by Policy #113.62, shall be provided.

4. Intake Dental Education: During the intake examination/treatment, instruction on basic oral hygiene and how to access dental services shall be provided.

C. General Dental Services:

1. Inmates shall access dental services by signing up for sick call. All dental staff shall provide dental services under the priorities outlined in Section (D) of this policy.

2. Scheduled Dental Treatment: Treatment shall be based on inmate needs as determined in the dental examination and according to the treatment priorities outlined in Section VI. (D) of this policy. Dental treatment shall include x-rays, restorative procedures, extractions, and dental specialties as defined in Policy #113.62. Current vital signs must be taken before an invasive procedure.

3. Dental Sick Call: Dental complaints shall be presented during the regularly scheduled sick call visit and will be conducted by a nurse. After the inmate is examined, the nurse shall document the complaint and objective assessment on the TDOC Nursing Protocol Progress Note (NPPN), Dental Pain, CR-4240. As appropriate, the nurse will refer such complaints to the institutional dentist on the Institutional Health Services Referral, CR-3431. (See Policy #113.11) The dentist will triage the complaints and provide treatment following recognized clinical priorities, making a special effort to care for dental emergencies (Category I) during the established dental sick call period. Initial dental and sick call visits are generally chargeable co-payment visits. (See Policy #113.15).

4. Follow-up Treatment: When follow-up treatment is necessary, either by request or because of the intake examination, the medical contractor or privately managed facility shall provide non-urgent care within six weeks of the sick call visit.

5. Emergency: Evaluative treatment of dental emergencies shall be available to inmates on a 24-hour basis. Such treatment may include:

   a. Relief of pain

   b. Emergency extractions

   c. Assessment of a fractured mandible with referral to an oral surgeon within 24 hours

   d. Control of bleeding and acute infection

   e. Emergency care patients with conditions such as bleeding or infection shall be seen by a dentist within 72 hours of the referral/sick call visit.

   f. The Contractor shall provide on-call coverage for dental emergencies twenty-four hours per day, seven days per week.

6. Preventive: Oral hygiene supplies (e.g., toothbrush, toothpaste, and dental floss-aids) shall be available to the inmates through the commissary unless prohibited for security and/or safety reasons. Dental hygiene education shall be provided at the permanently assigned institution by the dentist or designee as deemed necessary.

D. Dental Classification System: After an examination by the dentist, each inmate’s case shall be placed in a treatment category based on the examination results. The treatment category shall be recorded in the "Remarks" section of the Dental Record, CR-1889. Structuring priorities for dental care is not a replacement for professional dental judgment; instead, it is a guide for providing dental care to a specific population whose

incarceration may place a time limitation upon available dental services. Therefore, every effort should be made to prioritize Category I inmates.

1. Category I. Very Urgent; Requiring Immediate Attention:

   a. Pain or acute infection
   b. Teeth obviously requiring extraction
   c. Suspected neoplasm
   d. Trauma, fractures
   e. Acute periodontal conditions
   f. Uncontrolled bleeding

2. Category II. Moderately Urgent; Requiring Early Treatment:

   a. Dental caries into or near pulp
   b. Extensive penetration of dental caries into dentin
   c. Insufficient teeth to provide adequate mastication
   d. Edentulous oral cavity
   e. Replacement of ill-fitting removable appliances
   f. Heavy calculus causing pathology
   g. Chronic infections
   h. The presence of temporary restorations

3. Category III. Routine Dental Treatment:

   a. Incipient dental caries
   b. Periodontal treatment

4. Category IV. Maintenance care: No pressing requirement except for routine care and prophylaxis treatment. Category IV services shall only be provided after completing services for Category I - III patients.

5. Category V. (Exempt conditions): These dental procedures shall not be provided to TDOC patients.

   a. Third molars without pathology
   b. Fixed prosthodontics (bridges/crowns)
   c. Root canals
   d. Implants
   e. Bone grafts

E. Restorative Materials:

1. The permanent restorative materials of choice shall be silver amalgam and composites.

2. Temporary fillings shall be used for emergency fillings or where advisable due to the condition of the tooth.

3. Precious metals shall not be used.

F. Dental Records: Dental records are considered confidential and shall be maintained for each inmate as follows:

1. Dental staff shall record information gathered during the examination and document the dental treatment plan on the Dental Record, CR-1889. All dental treatments and orders shall be legible.

2. In accordance with Policy #113.04, when an inmate is transferred to another TDOC facility, the dental record shall be forwarded as part of the health record.

3. CR-1889 must be printed on cardstock, on one page, back, and front.

G. Dental Reports:

1. A daily work/encounter log shall be maintained for the dental clinic showing all dental work accomplished. The inmate's name, TDOC ID, type of procedure, appointment time, and name of dental staff member(s) providing the service shall be recorded. All dental instruments, including sharps, shall be documented on the encounter log. A separate log shall be maintained for the inventory, accountability, and control of all sharps used in the dental clinic.

2. A report of dental activities shall be completed each month using the Monthly Statistical Report, CR-2124. The dental authority or designee shall provide the institutional health administrator with all data required for institutional or departmental reports.

H. Consent/Refusal of Dental Treatment:

1. Written consent is not required for routine procedures where consent is implied by the inmate presenting himself/herself for treatment.

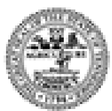
2. The dentist shall have a Consent for Treatment, CR-1897, signed by the inmate before performing extractions or other oral surgical procedures. The consent shall be specific to the procedure to be completed and list alternatives and possible complications to surgery.

3. If an inmate refuses the treatment recommended by the dentist, he/she may be removed from the dental waiting list and be required to sign up for a dental sick call to express his/her desire for dental treatment before being rescheduled. After being advised of the consequences of refusing services, the inmate shall sign a Refusal of Medical Services, CR-1984, which will then be filed with the dental records. These events shall be documented in the dental record and on the daily clinic log.

VII. APPLICABLE FORMS: CR-1889 (Rev. 01-2023), CR-1897 (Rev. 9/19), CR-1984 (Rev. 8/19), CR-2124 (Rev. 8/20), CR-3431 (Rev. 9/19), CR-4203 (Rev. 4/21), and CR-4240 (Rev. 6/22).

VIII. ACA STANDARDS: 5-ACI-6A-19, 5-ACI-6A-19-1, 5-ACI-6A-25, and 5-ACI-6B-02.

IX. EXPIRATION DATE: March 20, 2026



TENNESSEE DEPARTMENT OF CORRECTION
DENTAL RECORD

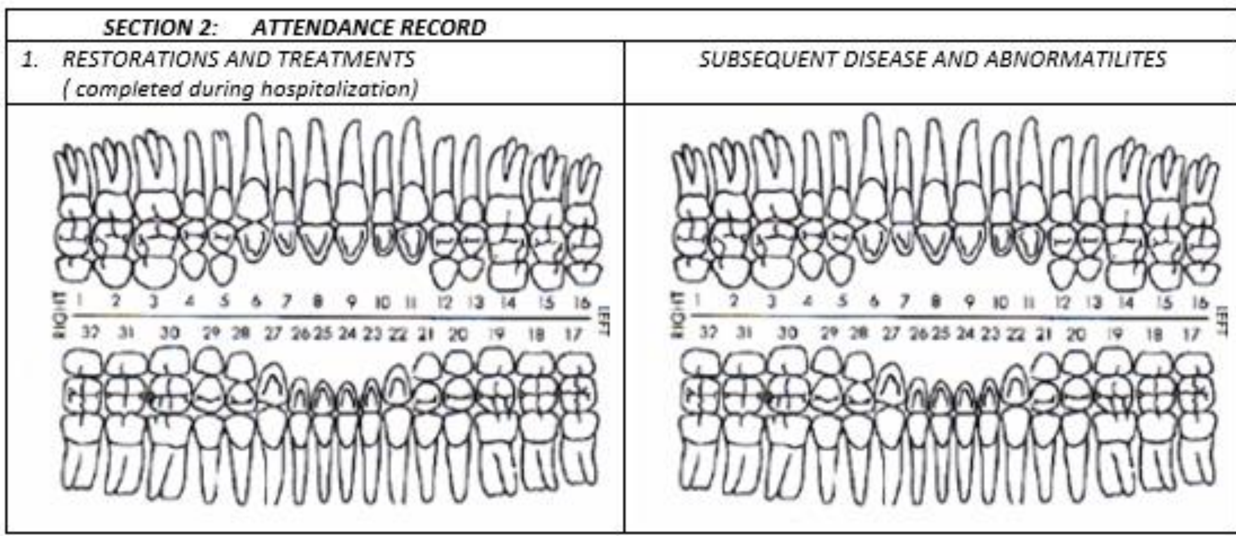
SECTION 1: **DENTAL EXAMINATION**	**RESTORATION AND TREATMENTS**			
RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17	RIGHT 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 LEFT 32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17			
Date of Initial Examination:	**Comments**			
Oral Pathology:	Treatment Category:			
Gingivitis, Vincent's Angina, Stomatitis	OHI			
Periodontoclasia				
Incipient, Moderate, Severe	PSR/ CPITN			
Other Findings				
Calculus: Light, Moderate, Severe	Oral Hygiene	Good	Fair	Poor
Radiographs:				
Periapical, BTW, Panorex	Allergies:			
Oral Cancer Exam				
Prosthetic:	**Education:** ☐Oral Hygiene ☐ Oral Disease ☐ Self-Care			
Denture, RPD, CD, Upper, Lower				
Initial Treatment Plan:				

Examination Completed by: ______________________________ Title: ____________________

Inmate Name:	TDOC ID:	DOB:
Institution:	Date:	

SECTION 2: ATTENDANCE RECORD

1. RESTORATIONS AND TREATMENTS (completed during hospitalization)	*SUBSEQUENT DISEASE AND ABNORMATILITES*



ALLERGIES:

DATE/ TIME/ LOCATION/ TX. CAT.	SERVICES PROVIDED	PROVIDER

Inmate Name:	TDOC ID:	DOB:

TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES
CONSENT FOR TREATMENT

____
INSTITUTION

Name: ______________________________ TDOC ID: ______________ Date of Birth: ______________
Last First Middle

I hereby authorize ______________ (Practitioner) and assistants to perform the following operation, procedure, treatment, or psychiatric intervention.

____
Use Laymans Terms

The nature and extent of the intended operation, procedure, treatment, or psychiatric intervention has been explained to me in detail. I have been advised by ______________________ (Practitioner) of the following alternatives, if any, probable consequences if I remain untreated, risks and possible complications of proposed treatment as indicated:

____
(Use Layman's Terms)

I acknowledge that no guarantee or assurance has been made as to the result that may be obtained.

If any unforeseen condition arises in the course of the operation calling for the judgment of the practitioner for procedures in addition to or different from those now contemplated, I further request and authorize the practitioner to do whatever is deemed necessary.

I consent to the administration of anesthesia to be applied under the direction and supervision of ______________ (Practitioner).

I have read and fully understand the terms of this consent and acknowledge that the explanations referred to were made and that all blanks have been filled.

Date: ______________ Time: ______________ ______________________
(Signature of Patient)

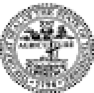
Witness: ______________________ ______________________ ______________
(Signature of Practitioner and Professional Title) Date

If the patient is a minor or incompetent to consent:

______________________ Date: ______________ Time: ______________ a.m p.m.
(Signature of parent or person authorized to consent for patient)

Witness: ______________________ Witness: ______________________

CR-1897 (Rev. 9-19) *Duplicate as Needed* Original: Health Record RDA 1458



TENNESSEE DEPARTMENT OF CORRECTION
HEALTH SERVICES
REFUSAL OF MEDICAL SERVICES

INSTITUTION: ______________________________

Date ____________ 20 ____ Time ________ AM/PM

This is to certify that I ____________ (Inmate's Name) ____________, ______ (TDOC ID) ______

have been advised that I have been scheduled for the following medical services and/or have been advised to have the following evaluations, treatment, or surgical/other procedures:

____

____

____

I am refusing the above listed medical services against the advice of the attending physician and/or the Health Services staff. I acknowledge that I have been informed of the risks involved by my refusal and hereby release the State of Tennessee, Department of Correction, and their employees from all responsibility for any ill effects which may be experienced as a result of this refusal. I also acknowledge this medical service may not be made readily available to me in the future unless an attending physician certifies my medical problem as a medical emergency.

Signed: ______________________ (Inmate) ____________ (TDOC ID) ________ (Date)

Witness: ______________________ (Signature) ____________ (Title) ________ (Date)

The above information has been read and explained to,

______________________ (Inmate's Name) ____________ (TDOC ID) but has refused to sign the form.

Witness: ______________________ (Signature) ____________ (Title) ________ (Date)

Witness: ______________________ (Signature) ____________ (Title) ________ (Date)

TENNESSEE DEPARTMENT OF CORRECTION
MONTHLY STATISTICAL REPORT

	AUTO-CALCULATED CELL-- DO NOT ENTER DATA													
	DUE BY THE 8th OF EACH MONTH													
	NAME OF INSTITUTION													
	Monthly Data:	January	February	March	April	May	June	July	August	September	October	November	December	TOTAL/AVG
8	Average Daily Population (ADP from count room on last day of the month)													
9	Number of Safe Keeper Inmates (Total for the month from count room)													
10	**ACA**													
11	MRSA (MRSA Log)													
12	(1A1) Number of offenders newly diagnosed with MRSA infection this month. Soft tissue infections empirically treated as MRSA should be tracked as a component of this outcome measure.													
13	ACA Calculated Outcome Measure (line 12/line 8)													
14	TUBERCULOSIS (TB Log)													
15	(1A2) Number of offenders newly diagnosed with active tuberculosis this month													
16	ACA Calculated Outcome Measure (line 15/line 8)													
17	(1A3) Number of offenders who are new converters on a TB skin test (TST) that indicates newly acquired TB infection													
18	(1A3) Number of offenders administered skin tests for TB (TST) as part of annual, periodic, or clinically based testing, but not intake screening													
19	ACA Calculated Outcome Measure (line 17/line 18)													
20	Number of offenders screened for TB as part of annual, periodic, or clinically based testing, but not intake screening													
21	Number of TST completed as part of the intake Process (BCCX; DJRC; NWCX (juvenile))													
22	Total skin tests for TB (TSTs) (line 18+line 21)													
23	Number of IGRAs completed as part of annual, periodic, or clinically based testing, but not intake screening													
24	Number of IGRAs completed as part of the intake Process (BCCX &DJRC)													
25	Total number of IGRAs completed (line 23+line24)													
26	(1A4) Number of offenders who completed treatment for latent tuberculosis infection													
27	(1A4) Number of offenders started on treatment for latent tuberculosis infection													
28	Number of offenders who STOPPED/DID NOT COMPLETE treatment for latent tuberculosis infection													
29	ACA Calculated Outcome Measure (line 26/line27)													
30	HEPATITIS C (HCV Log)													
31	(1A5) Number of offenders diagnosed with Hepatitis C viral infection													
32	ACA Calculated Outcome Measure (line 31/line 8)													
33	Number of offenders with Hepatitis C viral infection being treated with antiretroviral treatment													
34	Number of offenders diagnosed with Hepatitis A viral infection (New cases only)													
35	Number of offenders diagnosed with Hepatitis B viral infection (New cases only)													
36	Number of Hepatitis B vaccines administered													

TENNESSEE DEPARTMENT OF CORRECTION
MONTHLY STATISTICAL REPORT

	AUTO-CALCULATED CELL-- DO NOT ENTER DATA													
	DUE BY THE 8th OF EACH MONTH													
	NAME OF INSTITUTION													
	Monthly Data:	January	February	March	April	May	June	July	August	September	October	November	December	TOTAL/AVG
37	HIV/AIDS (HIV Log)													
38	(1A6) Number of offenders diagnosed with HIV infection													
39	ACA Calculated Outcome Measure (line 38/line 8)													
40	(1A7) Number of offenders with HIV infection who are being treated with highly active antiretroviral treatment (HAART)													
41	ACA Calculated Outcome Measure (line 40/line 38)													
42	(1A8) Number of selected offenders with HIV infection at a given point in time who have been on antiretroviral therapy for at least six months with a viral load of less that 50 cps/mle													
43	(1A8)Total number of treated offenders with HIV infection who were reviewed (25 or total number of pts; whichever is smaller)													
44	ACA Calculated Outcome Measure (cell O 42/cell O 43)													
45	Total number of confirmed cases of AIDS													
46	MENTAL HEALTH (MHA)													
47	(1A9) Number of offenders diagnosed with an individulized services/treatment plan for a diagnosed mental disorder (excluding sole dx of substance abuse).													
48	ACA Calculated Outcome Measure (line 47/line 8)													
49	OFF-SITE HOSPITAL ADMISSIONS / ER TRANSPORTS (Daily Inpatient Report/ER Transfer Log)													
50	(1A10) Number of offender admissions to off-site hospitals													
51	ACA Calculated Outcome Measure (line 50 / line 8)													
52	(1A11) Number of offenders transported off-site for treatment of emergency health conditions													
53	ACA Calculated Outcome Measure (line 52/ line 8)													
54	CONSULTS (Consult Log)													
55	(1A12) Number of offender specialty referrals completed													
56	(1A12) Number of specialty referrals (on-site or off-site) ordered by primary health care practitioners													
57	ACA Calculated Outcome Measure (line 55/line 56)													
58	HYPERTENSION (CCC Log)													
59	(1A13) Number of selected hypertensive offenders with blood pressure reading > 140/> 90 mmHg													
60	(1A13) Total number of offenders with hypertension who were reviewed (25 or total number of pts; whichever is smaller)													
61	ACA Calculated Outcome Measure (cell K 59/cell K 60)													
62	DIABETES (CCC Log)													
63	(1A14) Number of selected diabetic offenders who are under treatment for at least six months with a hemoglobin A1C level measuring greater than 9 percent													
64	(1A14) Total number of diabetic offenders who were reviewed (25 or total number of pts; whichever is smaller)													
65	ACA Calculated Outcome Measure (cell R 63/cell R 64)													

TENNESSEE DEPARTMENT OF CORRECTION

MONTHLY STATISTICAL REPORT

	AUTO-CALCULATED CELL-- DO NOT ENTER DATA														
	DUE BY THE 8th OF EACH MONTH														
	NAME OF INSTITUTION														
	Monthly Data:		January	February	March	April	May	June	July	August	September	October	November	December	TOTAL/AVG
66	DENTAL (Dental Department)														
67	(1A15) Number of completed dental treatment plans														

TENNESSEE DEPARTMENT OF CORRECTION
INSTITUTIONAL HEALTH SERVICES REFERRAL

____
INSTITUTION

☐ MEDICAL ☐ DENTAL
☐ BEHAVIORAL HEALTH

INMATE: ____________________________________ TDOC ID: ______________
Last First Middle

PRESENTING PROBLEMS: ____________________________________

REFERRED BY: ________________________ __________ __________
Signature/Title Date Time

SEND REFERRAL FORM TO INSTITUTIONAL HEALTH COORDINATOR

☐ Behavioral Health
☐ Medical ☐ Dental

RECEIVED BY: ________________________ __________ __________
Signature/Professional Title Date Time

REFERRAL DISPOSITION (Course of Action): ____________________________________

________________________ DATE: __________ TIME: __________

____
Signature/Professional Title

TENNESSEE DEPARTMENT OF CORRECTION

INTAKE DENTAL QUESTIONNAIRE

INQUIRE:

1. Are you in good health? .... Y ☐ N ☐
   Has there been any change in your general health within the past year? .... Y ☐ N ☐
2. Are you under the care of a physician? .... Y ☐ N ☐
   If yes, what is the condition being treated? ____________________
3. Have you had any serious illnesses or operations? .... Y ☐ N ☐
   If yes, what was the problem? ____________________
4. Do you or have you had any of the following diseases or problems?

Rheumatic Fever	Y ☐ N ☐	Fainting Spells/Seizures/Epilepsy	Y ☐ N ☐
Heart Murmur	Y ☐ N ☐	Diabetes	Y ☐ N ☐
Heart Disease	Y ☐ N ☐	Jaundice/Hepatitis	Y ☐ N ☐
High Blood Pressure	Y ☐ N ☐	Liver Disease	Y ☐ N ☐
Low Blood Pressure	Y ☐ N ☐	Inflammatory Rheumatism	Y ☐ N ☐
Stroke	Y ☐ N ☐	Stomach Ulcers	Y ☐ N ☐
Chest Pain	Y ☐ N ☐	Kidney Trouble	Y ☐ N ☐
Shortness of Breath	Y ☐ N ☐	Tuberculosis (INH Treatment)	Y ☐ N ☐
Swollen Ankles	Y ☐ N ☐	STI-Syphilis/Gonorrhea	Y ☐ N ☐
Artificial Heart Valves	Y ☐ N ☐	HIV+/AIDS	Y ☐ N ☐
Prosthetic Joints	Y ☐ N ☐	IV Drug Use	Y ☐ N ☐
Seasonal Allergies	Y ☐ N ☐	Sickle Cell Anemia	Y ☐ N ☐
Asthma	Y ☐ N ☐	Hemophilia	Y ☐ N ☐
Hives/Skin Rash	Y ☐ N ☐	Anemia	Y ☐ N ☐
Thyroid Problems	Y ☐ N ☐	Other (list): ____________	
Cancer/Tumors/Cysts	Y ☐ N ☐		

5. Have you had any abnormal bleeding associated with previous tooth extraction, dental surgery, or trauma? .... Y ☐ N ☐
6. Have you had any prior serious trouble with dental treatment? .... Y ☐ N ☐
7. Have you ever had treatment for cancer of your head or neck, including surgery, radiation treatment, or chemotherapy? .... Y ☐ N ☐
8. Do you bruise easily? .... Y ☐ N ☐
9. Have you ever required a blood transfusion? .... Y ☐ N ☐
   If yes, approximate date: ____________ Explain the circumstances: ____________
10. List all medications you are presently taking or have taken in the last two weeks (include any over-the-counter medication): ____________
____
11. Are you allergic to or have you ever reacted to:

Local Anesthetics/Novocaine	Y ☐ N ☐	Iodine/Seafood	Y ☐ N ☐
Penicillin/Antibiotics	Y ☐ N ☐	Nickel Metals	Y ☐ N ☐
Sulfa Drugs	Y ☐ N ☐	Latex	Y ☐ N ☐
Aspirin, Tylenol or Motrin	Y ☐ N ☐	Other (list): ____________	

12. Do you have any disease, condition or problem not listed above that you think I should know about? .... Y ☐ N ☐
13. Are you pregnant? .... Y ☐ N ☐ N/A ☐
    If yes, how many months? ____________
14. Do you have any problems associated with your menstrual period? .... Y ☐ N ☐ N/A ☐

Comments: ____________________

I certify that the foregoing information supplied by me is true and complete to the best of my knowledge.

____
Date Signature of Patient Signature of Dental Staff Reviewing History

Inmate Name:		TDOC ID:	DOB:
Institution:	Date:		

TENNESSEE DEPARTMENT OF CORRECTION

NURSING PROTOCOL PROGRESS NOTE – DENTAL PAIN

____
INSTITUTION

Name: ____ TDOC ID: ______________

Date/Time: ________________________ Allergies: ______________________________

***See MAR for current medications**: Compliant? ☐ Y ☐ N Recent change? ☐ Y ☐ N If Yes, describe: ______________

Subjective: Chief Complaint-

Onset: ______________________ Duration: ______________________

Recent Dental Work: ☐ Y ☐ N   **Facial Trauma:** ☐ Y ☐ N   **Drug Ingestion:** ☐ Y ☐ N

Activity prior to onset: ______________________________ *Prior history of same* ☐ Y ☐ N

If yes, what was the treatment and when? ______________________________

History of: ☐ Drug Abuse ☐ Heart Disease ☐Diabetes

Aggravating Factors: ☐ None ☐ Temp ☐ Jaw Movement ☐ Chewing

Pain Scale (0-10): __________ ☐ Sharp ☐ Dull ☐ Constant ☐ Stabbing ☐ Intermittent

Location of Pain: ______________________________

Associated Symptoms: ☐ None ☐ Nausea ☐ Vomiting ☐ Fever/Chills ☐ Facial/Neck Swelling
☐ Difficulty Swallowing ☐ Bad Breath ☐ Other: ______________________________

Objective:

Vital Signs: T: P: R: BP: / O2 Sat: ________ Weight: ________

Gen Appearance: ☐ Alert, Oriented & No Distress ☐ Alert & Distressed ☐ Alert-Not Oriented

FLACC Pain Score: ______________

Place "X" on affected tooth

Central incisor
Lateral incisor
Canine
First premolar
Second premolar
First molar
Second molar
Third molar
Second molar
Third molar
First molar
Second premolar
First premolar
Canine
Lateral incisor
Central incisor

Skin: ☐ Norm ☐ Dry ☐ Warm ☐ Moist/Clammy ☐ Pale ☐ Cyanotic ☐ Jaundice

Head Trauma: ☐ None ☐ Y-Describe ______________________ ☐ Facial Asymmetry

Neck and Jaw: ☐ Norm ☐ Swollen ☐ Tender on Palpation ☐ Pain reproduced with movement

Gums: ☐ Norm ☐ Red ☐ Swollen ☐ Lesions ☐ Bleeding ☐ Bad Breath ☐ Visible Lesions ☐ Tooth Abnormality

Additional Examination: ______________________________

____

**Use blank CR-1884 for addl. Documentation*

Assessment: Alteration in Comfort due to Dental Pain

Plan: Provide treatment per Nursing Protocol

Duplicate as Needed

TENNESSEE DEPARTMENT OF CORRECTION Name:_______________

NURSING PROTOCOL PROGRESS NOTE – DENTAL PAIN TDOC ID:__________

☐ Emergent Life Threatening or Patient in Extreme Distress – Activate EMS	☐ Urgent Notify Provider Directly if:	☐ Routine Refer to Provider if:
☐ Active Bleeding **ON** Anticoagulant **Interventions:** ☐Oxygen@ 2-15Liters 2-6 L/min via NC or 15 L/min NRB to maintain O2 saturation =>95% ☐Place in most comfortable position ☐Elevate legs, if SBP<90 ☐Monitor vital signs q5mins until EMS arrive ☐Start IV with Normal Saline 0.9% 500 ml/hr. for Systolic BP < 90, otherwise KVO, or per Provider's order **Site:** _________ **# of attempts:** ____ **Gauge:** _______ **Time:** __________ **Pt. tolerated:** ☐**Well** ☐**Fair** ☐**Poor** **Time provider notified**_________ **Time provider responded**_______ ☐ **Orders received** ☐ **No**	**SBP** <90 or >170; **DBP**>100; **T**>100.4; **RR** <10 or >24; **HR** <60 or >100; **O2Sat** <=94% ☐ Active Bleeding **NOT** on Anticoagulant ☐ Drooling ☐ Difficulty with Swelling ☐ Avulsed Tooth ☐ Abscessed Tooth ☐ Fractured/Displaced Jaw ☐ Fractured Maxilla/Eye Socket ☐ Pain 7/10 ☐ Patient Education Provided ☐ Patient instructed to resubmit sick call if problem worsens, does not improve, or new symptoms develop. **Complete Sexual History Screening on all patients.* **Time provider notified** ________ **Time provider responded**______ ☐ **Orders received** ☐ **No**	☐ **Protocol Treatment ineffective x 2 within 7 days** ☐ **Protocol does not adequately meet the patient's objective clinical needs** **Interventions:** ☐ Acetaminophen 325 mg tabs PO, 2 tabs 3 x daily PRN x 4 days for pain **OR** ☐ Ibuprofen 200 mg tabs PO, 2 tabs 3x daily PRN x 4 days for pain ☐ Patient Education Provided ☐ Patient instructed to resubmit sick call if problem worsens, does not improve, or new symptoms develop. **Sexual History Screening:* Have you ever had any STDs? ☐Yes ☐No What do you do to protect yourself from STDs and HIV? ______________________ What concerns about STDs do you have? ______________________ Review/provision of the appropriate level of risk-reduction/abstinence handout and counseling for each patient.

Emergency Transport

☐Time EMS Notified: ________________________

☐ Emergency Room transfer documentation completed

☐ Emergency Room notified; Report Given to: ______________________________

Depart Date/ Time: ____________________ Type of Transport: ____________________

______________________ ______________________ ____________

LPN Signature Printed Name Date

OR (*Routine*) Both *(Urgent/ Emergent)*

______________________ ______________________ ____________

RN Signature Printed Name Date