**DENTAL QUALITY ASSURANCE**
**CHART REVIEW AUDIT FORM – 1**

Date:_____ Clinic: _____ Reviewer: _____

Patient Name: _____ Identification #: _____

**A. Radiographic Assessment**
Review all radiographs taken during the last two years, check all criteria using the definitions in the manual.

| | YES | NO |
|---|---|---|
| 1. Sufficient quantity of films taken | ☐ | ☐ |
| 2. All film mounts and packets dated | ☐ | ☐ |
| 3. All film mounts and packets have patient identification number | ☐ | ☐ |
| 4. All film mounts and packets have patient name | ☐ | ☐ |

5. Quality - check problem areas

- ☐ Insufficient contrast
- ☐ Distortion(elongation)
- ☐ Cone cut
- ☐ Other_____ SPECIFY
- ☐ Overlapping images
- ☐ Apex not shown
- ☐ Poor developing

| | ACCEPTABLE | NOT ACCEPTABLE |
|---|---|---|
| Overall estimation of quality of radiographs | ☐ | ☐ |

**B. Dental Record Assessment**
Check if all criteria are present or absent. If present, check if acceptable or not acceptable using definitions in the manual.

| | PRESENT | ABSENT | ACCEPTABLE | NOT ACCEPTABLE |
|---|---|---|---|---|
| 1. Patient identification | ☐ | ☐ | ☐ | ☐ |
| 2. Dental consent | ☐ | ☐ | ☐ | ☐ |
| 3. Medical history | ☐ | ☐ | ☐ | ☐ |
| 4. Extraoral/intraoral examination | ☐ | ☐ | ☐ | ☐ |
| 5. Dental charting | ☐ | ☐ | ☐ | ☐ |
| 6. Problem list/treatment plan | ☐ | ☐ | ☐ | ☐ |
| 7. Progress notes | ☐ | ☐ | ☐ | ☐ |

**COMMENTS:**

# DENTAL QUALITY ASSURANCE
# CHART REVIEW AUDIT FORM - 2

Patient Name_____Identification #_____

**C. Assessment of Treatment**

Review the record for the first four criteria. Use judgment for the overall assessment of each of these criteria using the explanations in the manual as a guide. All criteria deemed not acceptable must have an explanation in the COMMENTS section.

**1. Completeness of Diagnosis** **COMMENTS**

Check problems overlooked or not noted in treatment.

☐ Caries ☐ Gingivitis ☐ Periodontitis
☐ Missing teeth ☐ TMD/facial pain ☐ Oral pathology
☐ Periapical pathology ☐ Malocclusion ☐ Space maintenance

**Assessment of Diagnosis:** ☐ Acceptable ☐ Not Acceptable

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**2. Integration of Non-dental Considerations**

Check areas not appropriately considered in treatment.

☐ Medical ☐ Emotional ☐ Medications ☐ Lifestyle

**Assessment of Non-dental Considerations:**

☐ Acceptable ☐ Not Acceptable ☐ Not Applicable

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**3. Appropriateness of Treatment**

a. Appropriateness of Curative Treatment

Check services considered inappropriate.

☐ Restorative ☐ Periodontics ☐ Endodontics
☐ Removable prosthetics ☐ Fixed prosthetics ☐ Pulp protection
☐ Oral surgery ☐ Orthodontics ☐ Space maintenance
☐ Medication prescribed ☐ Other_____
SPECIFY

**Assessment of Appropriateness of Curative Treatment:**

☐ Acceptable ☐ Not Acceptable

b. Appropriateness of Preventive Care

Review preventive care in record.

**Assessment of Preventive Care:** ☐ Acceptable ☐ Not Acceptable

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**4. Logical Sequence of Treatment**

Check areas that are not judged to be in proper sequence.

☐ Pain control ☐ Caries control ☐ Pulpal therapy
☐ Preventive care ☐ Orthodontics ☐ Periodontal therapy
☐ Space maintenance ☐ Oral surgery
☐ Restoration of missing teeth ☐ Other_____
SPECIFY

**Assessment of Logical Sequence of Treatment:**

☐ Acceptable ☐ Not Acceptable

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**5. Summary of Case Management**

Indicate the overall quality of the total management of patient care.

☐ Excellent ☐ Above Standard ☐ Adequate
☐ Below Standard ☐ Substandard