CAMBRIDGE ACADEMY OF
DENTAL IMPLANTOLOGY

STAGE 1

IMPLANT ASSESSMENT FORM

This form and all required artefacts are to be completed and submitted to the training centre. You will then be appointed a case supervisor who will treatment plan the case with you.

Patient name: ______________________________

Date of birth: ______________________________

Dentist name: ______________________________

Dentist address: ______________________________
____
____
____
____

Dentist telephone: ______________________________

Dentist email: ______________________________

Local Mentor: ______________________________

PLEASE INDICATE WHETHER YOU ARE SUBMITTING THIS AS A FORMATIVE CASE (FOR LEARNING FEEDBACK ONLY - NOT GRADED) OR AS A SUMMATIVE CASE (GRADED AND COUNTING TOWARDS YOUR MODULE MARK): PLEASE CIRCLE……

FORMATIVE **SUMMATIVE**

CHECKLIST

Before submitting this form to the Academy please ensure that all of the following items have also been submitted. Send the casts in a well-padded rigid container by Registered Post or courier (or as digital STL files if using an intraoral scanner). This form, the radiographs and the clinical photographs must be sent electronically. The form must be sent as a single PDG file. Please see module instructions on the Canvas LMS for details.

Radiographs sent **electronically**	❑
Clinical photographs sent **electronically**	❑
Copies* of study casts posted	❑
Occlusal records posted with casts	❑
Completed **ALL** sections of this form	❑
Please confirm that the patient has consented to the sharing of their information	❑

* **Do not** submit original casts. Only copies of casts as these are disposed of after completion of case assessment by the examiner.

SEND FORM, RADIOGRAPHS AND PHOTOGRAPHS ELECTRONICALLY TO:

info@CAofDI.COM

POST THE STUDY CASTS IN WELL PADDED RIGID BOX USING RECORDED POST TO:-

Cambridge Academy of Dental Implantology
PGDip Dental Implantology
Cavendish House
183 Arbury Road
Cambridge
CB4 2JJ

Clinical History

Brief description of patient’s social history (age, sex, occupation, etc) -

History of patient’s presenting complaint -

What areas are you considering for implant treatment –

Medical History

Patient Name ______________________________

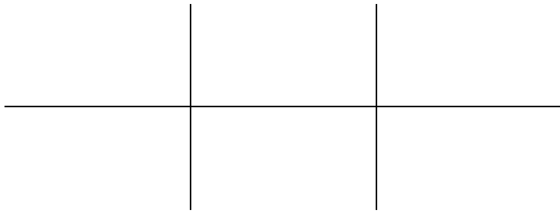
Date of birth ______________________________

Dentist's Name ______________________________

	Yes	No	Please give details…….
Have you ever had the following…			
Hayfever or eczema			
High blood pressure			
Bronchitis, asthma or any other chest or breathing problems			
Anaemia			
Epilepsy			
Kidney problems			
An allergic reaction			
Fainting attacks, giddiness or blackouts			
Gastric problems			
Depressive illness, anxiety or other psychological problems			
Drug or alcohol dependence			
Hepatitis, jaundice or HIV			
Arthritis			
Sinus problems			
A bad reaction to a general or local anaesthetic			
Severe headaches			
Heart valve or joint replacements			
Women only – are you pregnant or currently trying to get pregnant			
Do you bruise or bleed easily?			
Do you play contact sports?			
Have you ever smoked?			
How many units of alcohol would you drink in an average week?			
Medication			
Please list any medication that you have taken in the last 2 years			
Do you or your family have -			
Diabetes			
Heart disease			
Thyroid disease			
Osteoporosis			
Further medical history details:			

Periodontal Assessment

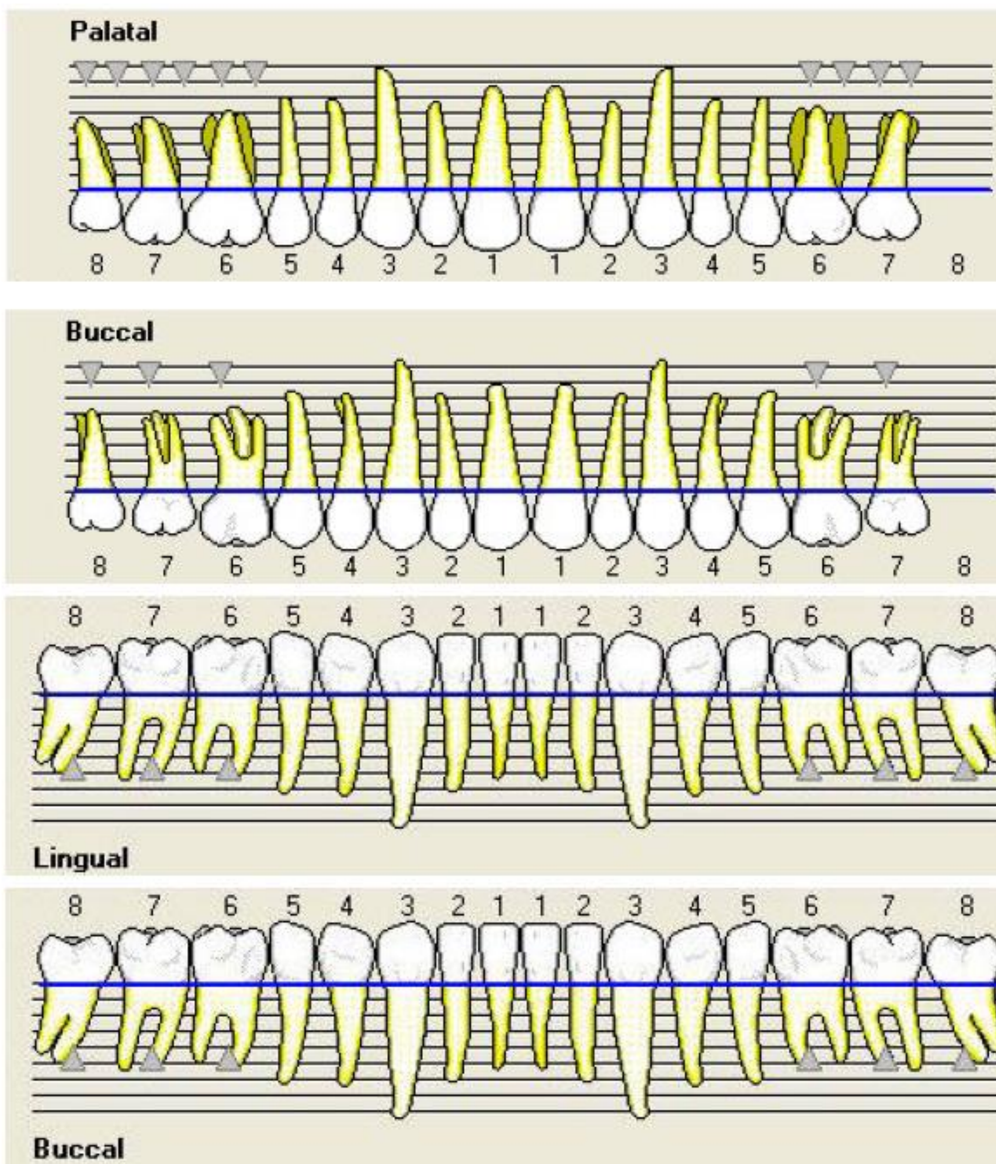
BPE CHART



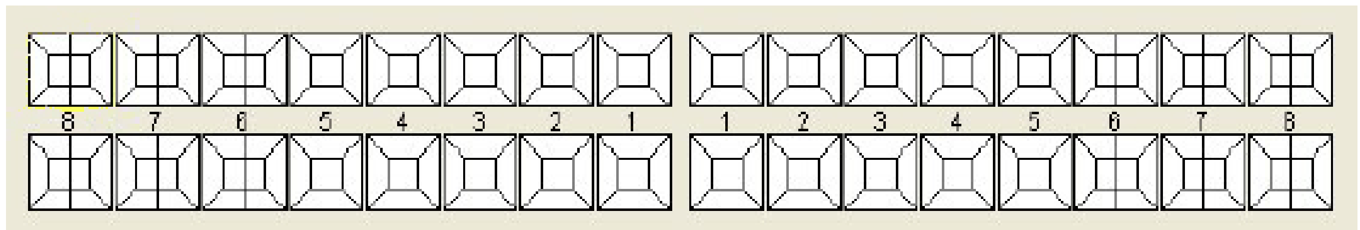
Oral hygiene status: VERY GOOD GOOD FAIR POOR DREADFUL

If any areas score '3' or above in BPE please complete a full periodontal examination for that sextant on the following charts:-

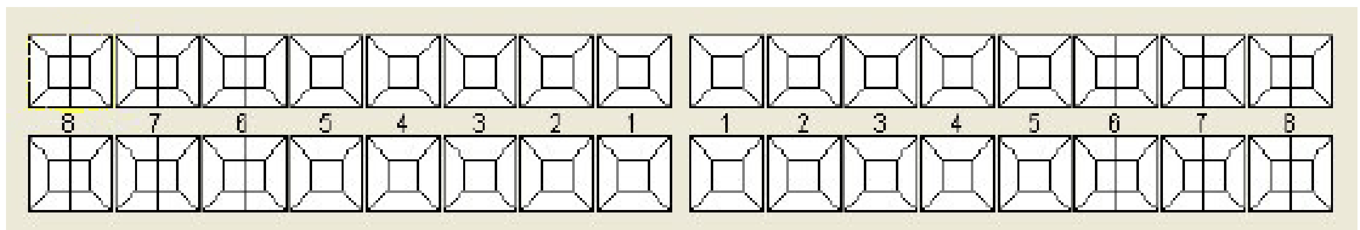
Draw in level of gingival margin and probing depths -



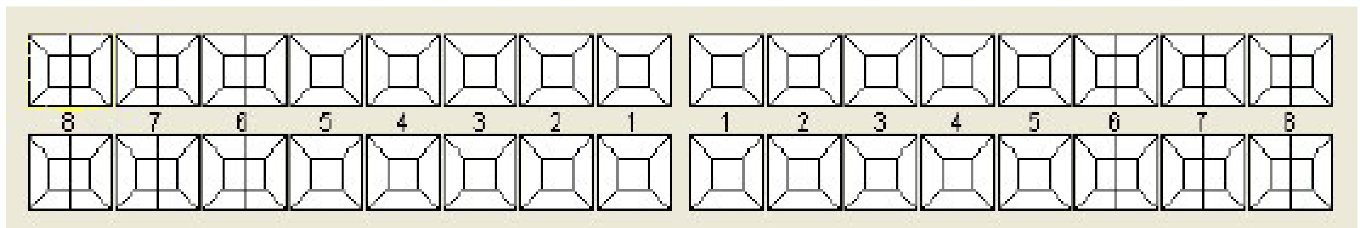
Bleeding points –



Mobile teeth –

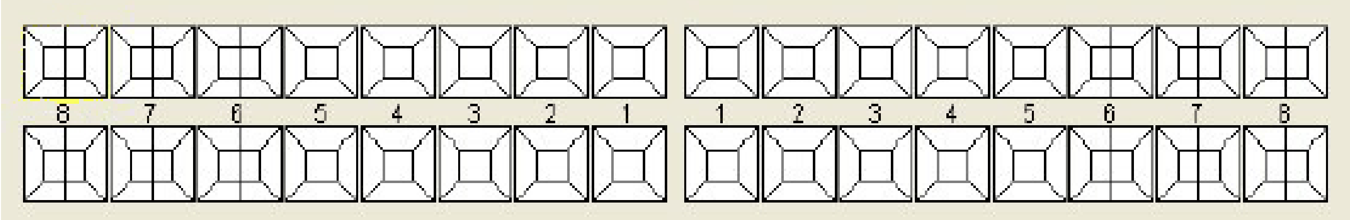


Furcation involvement –



Dental Assessment

Full dental charting:-



List ALL non implant related treatment required:

Suspect teeth:

Condition of teeth adjacent to edentulous space (check vitality, mobility etc):

Mucosal Assessment

Classification of mucosal biotype in region of interest:

Thin

Average

Thick

Width of keratinized attached mucosa on alveolar ridge/around tooth to be extracted:

Narrow

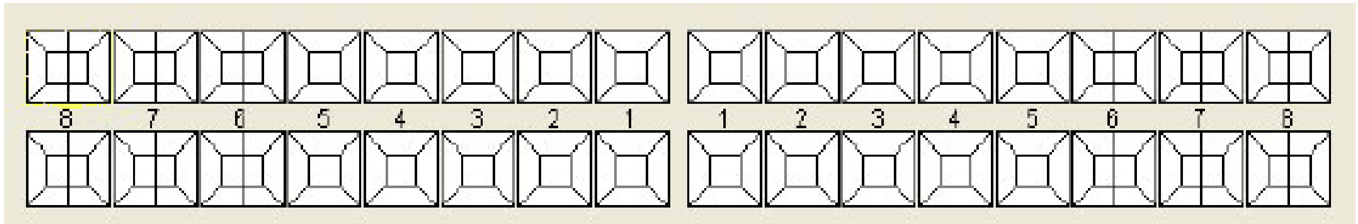
Average

Wide

Comments on the general condition of mucosa and position of mucogingival junction. For an edentulous case measure the width of the keratinised mucosa from the mucogingival junction to the crest of the ridge. For a dentate case measure the width of the keratinised mucosa from the gingival margin to the mucogingival junction.

Tooth Wear & Intraoral Soft Tissue Assessment

Indicate teeth with evidence of pathological wear:



Likely aetiological factor(s) of tooth wear (please circle) :

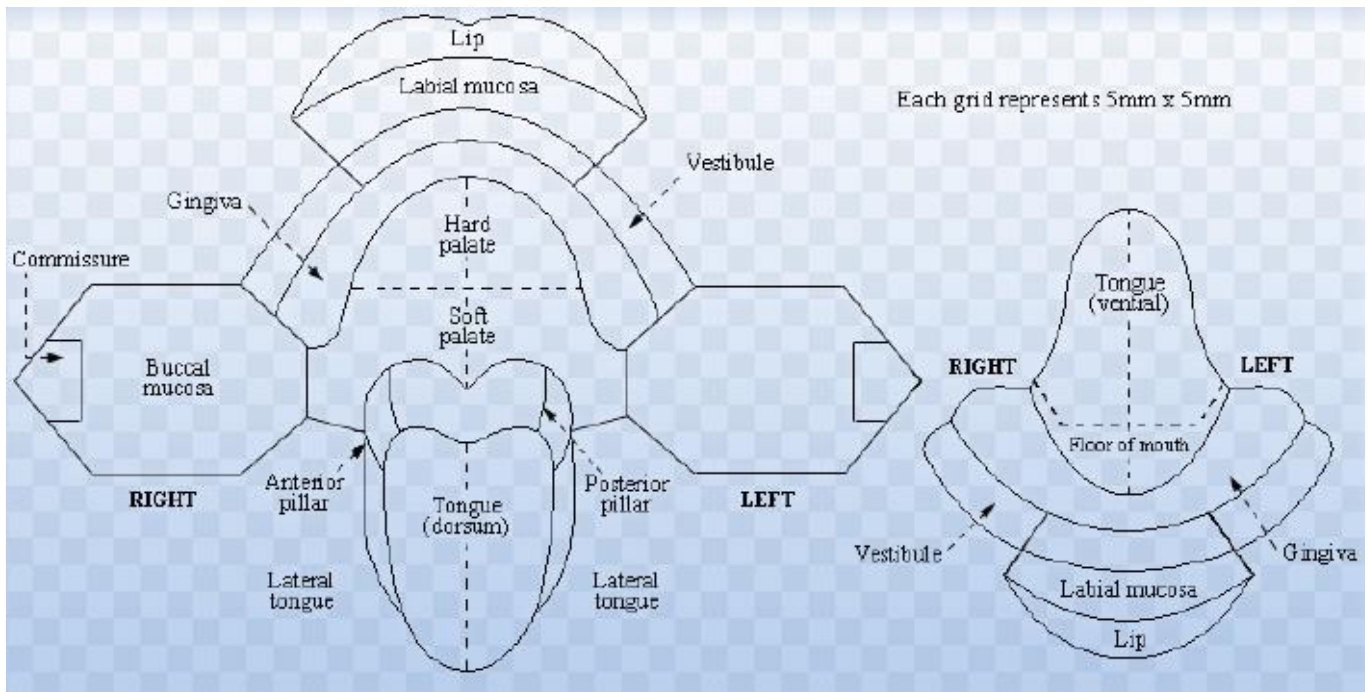
Attrition

Abrasion

Abfraction

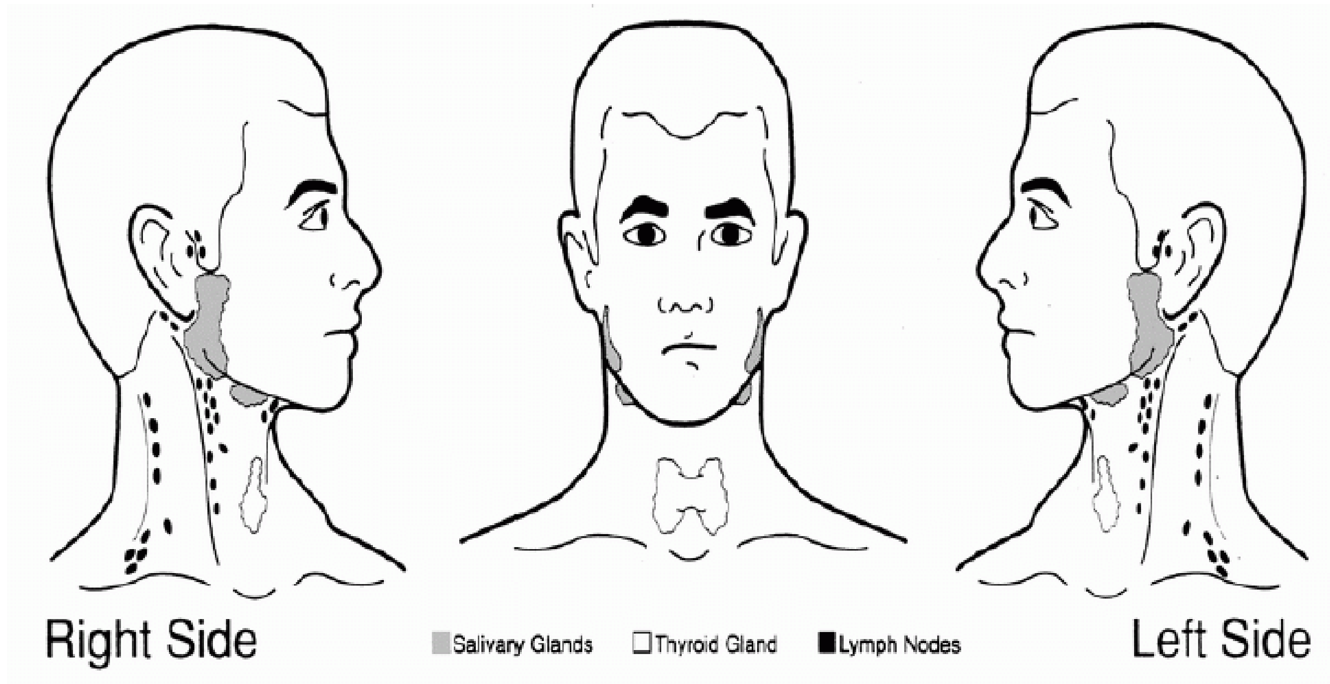
Erosion

Indicate any soft tissue lesions below:



Extraoral Assessment

Indicate any pathology on chart below and provide details in box:



Details of pathological findings:

TMJ & Occlusion

TMJ examination:

	RIGHT SIDE	LEFT SIDE
Tenderness to palpation		
Click on opening/closing		
Pain on opening/closing		
Crepitus		

Muscles of mastication:

Lateral pterygoids	
Masseters	
Temporalis	

Working contacts:

Non-working contacts:

Protrusive guidance:

CRCP contacts:

Noted Risk Factors

Suspect teeth:

Anatomical proximity:

- ☐ Inferior dental nerve
- ☐ Mental foramen
- ☐ Palatine nerve
- ☐ Incisive canal
- ☐ Maxillary sinus
- ☐ Floor of nose
- ☐ Tuberosites
- ☐ Genial tubercles
- ☐ Tori

Local risk factors:

- ☐ High smile line
- ☐ Poor attached gingivae
- ☐ Poor papillae

Available bone as determined from the radiograph (mm):

Depth	
Mesiodistal width	
Labiolingual width*	

- Labiolingual dimensions can only be determined if the case has had a CT scan taken

Bone level at adjacent teeth (as determined on the radiograph):

	Mesial of space	**Distal of space**
< 5mm to contact point		
5-6mm to contact point		
> 7mm to contact point		

Clinical width of edentulous space (mm):	

Patient's aesthetic expectations (circle):

LOW MEDIUM HIGH

Radiography & Photography

DO NOT TAKE A CBCT SCAN UNTIL THIS HAS BEEN APPROVED BY THE CASE EXAMINER

Photographic views taken (circle) -

Occlusal Labial RHS buccal LHS buccal RHS facial LHS facial Front facial

Photographic & smile line comments :

Radiographic images taken –

☐ Periapicals ☐ OPT ☐ CBCT scan ☐ Other (please specify)

Radiographic report :

Overall diagnosis for this case (list all diagnoses including perio, occlusion, caries, space etc) –

Next stage

Now that you have completed the initial case assessment provide a detailed description of what you plan to do next in this specific case…

Reflective Statement

Provide a detailed reflection of this case assessment. Consider any particular risks that you have identified, any special precautions required, any issues that may affect consent etc…