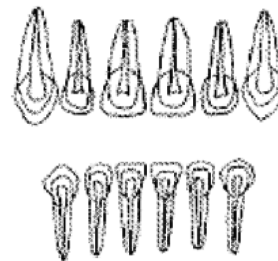


Assessment of Acute Traumatic Injuries

| | | |
|---|-----------------------------------|------------------------------------|
| ASSESSMENT OF ACUTE TRAUMATIC INJURIES | | PATIENT NAME: _____ |
| | | DATE OF BIRTH: _____ |
| DATE: | TIME: | REFERRED BY: |
| MEDICAL HISTORY: | | |
| ALLERGIES: | | DATE OF LAST TETANUS INNOCULATION: |
| DATE & TIME OF INJURY: | | TIME LAPSED SINCE INJURY: |
| WHERE INJURY OCCURRED: | | |
| HOW INJURY OCCURRED: | | |
| HISTORY | Check if present and describe: | MANAGEMENT PRIOR TO EXAM |
| | Non-dental Injuries | By Whom: Describe: |
| | Loss of consciousness | |
| | Altered orientation/mental status | |
| | Hemorrhage from nose/ears | |
| | Headache/nausea/vomiting | |
| | Neck pain | |
| | Spontaneous dental pain | |
| | Pain on mastication | |
| | Reaction to thermal changes | |
| | Previous dental trauma | |
| | Non-nutritive oral habits | |
| | Other complaints | |
| EXTRAORAL EXAM | Check if present and describe: | |
| | Cranial nerve deficit | |
| | Facial fractures | |
| | Lacerations | |
| | Contusions | |
| | Swelling | |
| | Abrasions | |
| | Hemorrhage/drainage | |
| | Foreign bodies | |
| | TMJ deviation/asymmetry | |
| INTRA-ORAL EXAMINATION | Check if injured and describe | DIAGRAM OF INJURIES |
| | Lips | |
| | Frenae | |
| | Buccal Mucosa | |
| | Gingivae | |
| | Palate | |
| | Tongue | |
| | Floor of mouth | |
| | Occlusion | |
| | Molar classification R ___ L ___ | |
| | Canine classification R ___ L ___ | |
| | Overbite (%) _____ | |
| | Overjet (mm) _____ | |
| Crossbite Y N | | |
| Midline Deviation Y N | | |
| Interferences Y N | | |



| | | | | | |
|------------------------------|-------------------------------------|-----------------|--------------------|--|--|
| DENTAL INJURIES | TOOTH NUMBER | | | | |
| | AVULSION | Extra-oral Time | | | |
| | | Storage Medium | | | |
| | INFRACTION | | | | |
| | CROWN FRACTURE | | | | |
| | PULP EXPOSURE | Size | | | |
| | | Appearance | | | |
| | COLOR | | | | |
| | MOBILITY (mm) | | | | |
| | PERCUSSION | | | | |
| | LUXATION | Direction | | | |
| | | Extent | | | |
| | PULP TESTING | Electric | | | |
| | Thermal | | | | |
| CARIES/PREVIOUS RESTORATIONS | | | | | |
| RADIOGRAPHS | PULP SIZE | | | | |
| | ROOT DEVELOPMENT | | | | |
| | ROOT FRACTURE | | | | |
| | PERIODONTAL LIGAMENT SPACE | | | | |
| | PERIAPICAL PATHOLOGY | | | | |
| | ALVEOLAR FRACTURE | | | | |
| | FOREIGN BODY | | | | |
| | DEVELOPMENTAL ANOMALY | | | | |
| | OTHER | | | | |
| TREATMENT | Check if performed and describe | SUMMARY | | | |
| | Soft tissue management | | | | |
| | Medication | | | | |
| | Pulp therapy | | | | |
| | Root conditioning | | | | |
| | Repositioning | | | | |
| | Stabilization | | | | |
| | Restoration | | | | |
| | Extraction | | | | |
| | Prescription | | | | |
| | Referral | | | | |
| | Other | | | | |
| | INSTRUCTIONS AND DISPOSITION | | Check if discussed | | |
| Diet | | | | | |
| Hygiene | | | | | |
| Pain | | | | | |
| Swelling | | | | | |
| Infection | | | | | |
| Prescription | | | | | |
| Complications: | | | | | |
| Damage to developing teeth | | | | | |
| Abnormal position/ankylosis | | | | | |
| Tooth Loss | | | | | |
| Pulp damage to injured teeth | | | | | |
| Other: | | | | | |
| Follow-up: | | | | | |
| Other | | | | | |

This sample form, developed by the American Academy of Pediatric Dentistry, is provided as a practice tool for pediatric dentists and other dentists treating children. It was developed by experts in pediatric dentistry, and offered to facilitate excellence in practice. However, this form does not establish or evidence a standard of care. In issuing this form, the American Academy of Pediatric Dentistry is not engaged in rendering legal or other professional advice. If such services are required, competent legal or other professional counsel should be sought.