Acute Traumatic Injuries: Assessment and Documentation

Patient name: _____ Date of birth: _____ Date: _____ Time: _____

Accompanied by: _____ Referred by: _____

HISTORY

MEDICAL HISTORY

Allergies: ❑ No ❑ Yes _____
Medications: ❑ No ❑ Yes _____
Last tetanus inoculation: _____
Other significant medical history:

HISTORY OF THE INCIDENT

Date & time of injury: _____
Time elapsed since injury: _____
Who witnessed event: _____
Description (what/where/how occured):

MANAGEMENT PRIOR TO EXAM

By whom? _____
Describe:

COMPLAINTS AND REPORTED CONDITIONS

Altered orientation/mental status	❑ No	❑ Yes	Pain on opening/closing mouth	❑ No	❑ Yes	Missing/avulsed tooth	❑ No	❑ Yes
Headache/nausea/vomiting	❑ No	❑ Yes	Abnormal/painful occlusion	❑ No	❑ Yes	Was missing tooth found?	❑ No	❑ Yes
Hemorrhage from ears/nose	❑ No	❑ Yes	Spontaneous dental pain	❑ No	❑ Yes	Transportation medium _____		
Loss of consciousness	❑ No	❑ Yes	Tooth sensitive to air/thermal change	❑ No	❑ Yes	Other complaints	❑ No	❑ Yes
Neck pain	❑ No	❑ Yes	Displaced or loosened tooth	❑ No	❑ Yes	Previous dental trauma	❑ No	❑ Yes
Wheezing/coughing/gagging	❑ No	❑ Yes	Fractured tooth	❑ No	❑ Yes	Use of oral appliance	❑ No	❑ Yes
Other bodily injuries	❑ No	❑ Yes	Was missing fragment found?	❑ No	❑ Yes	Nonnutritive oral habit	❑ No	❑ Yes

Description of positive findings:

EXTRAORAL EXAM

CRANIOFACIAL ASSESSMENT

Cranial nerve deficit	❑ No	❑ Yes	Hemorrhage/drainage	❑ No	❑ Yes	Laceration	❑ No	❑ Yes	Burns	❑ No	❑ Yes
Suspected facial fracture	❑ No	❑ Yes	Swelling	❑ No	❑ Yes	Abrasion	❑ No	❑ Yes	Foreign body	❑ No	❑ Yes
TMJ deviation/asymmetry	❑ No	❑ Yes	Contusion	❑ No	❑ Yes	Puncture	❑ No	❑ Yes	Other finding	❑ No	❑ Yes

Description of positive findings:

INTRAORAL EXAMINATION

SOFT TISSUES INJURIES

Lips	❑ No	❑ Yes	Buccal mucosa	❑ No	❑ Yes	Palate	❑ No	❑ Yes
Frenum	❑ No	❑ Yes	Tongue	❑ No	❑ Yes	Other	❑ No	❑ Yes
Gingiva	❑ No	❑ Yes	Floor of mouth	❑ No	❑ Yes			

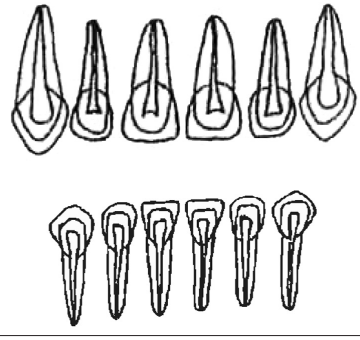
Description of positive findings:

OCCLUSAL ASSESSMENT

Molar classification	R_____	L_____	Crossbite	❑ No	❑ Yes
Canine classification	R_____	L_____	Midline deviation	❑ No	❑ Yes
Overbite (%) _____			Interferences	❑ No	❑ Yes
Overjet (mm) _____			Appliance present	❑ No	❑ Yes

Description of positive findings:

DIAGRAM OF INJURIES



OTHER COMMENTS

DENTAL ASSESSMENT	**TOOTH NUMBERS:**							
	Avulsion: Dry time / Storage medium							
	Infraction							
	Crown fracture							
	Pulp exposure: Size / Appearance							
	Mobility (mm)							
	Luxation: Direction / Extent							
	Percussion							
	Color							
	Pulp testing: Electric / Thermal							
	Caries/restorations							
	Other							
RADIOGRAPHS	Pulp size							
	Root development							
	Root fracture							
	Periodontal ligament space							
	Periapical pathology							
	Alveolar fracture							
	Foreign body							
	Other							

✓		
	All avulsions and fragments located?	❑ No ❑ Yes
	Loose, broken, or missing appliance?	❑ No ❑ Yes
	Photographs obtained?	❑ No ❑ Yes
	Suspected or confirmed abuse?	❑ No ❑ Yes

SUMMARY

TREATMENT

CHECK IF PERFORMED

- ❑ Soft tissue management
- ❑ Anesthesia/medication
- ❑ Repositioning/reimplantation
- ❑ Stabilization
- ❑ Pulp therapy
- ❑ Restoration
- ❑ Extraction
- ❑ Prescription
- ❑ Other: _____

INSTRUCTIONS AND DISPOSITION

CHECK IF DISCUSSED

- ❑ Diet
- ❑ Hygiene
- ❑ Pain/pain control
- ❑ Swelling
- ❑ Infection
- ❑ Prescription
- ❑ Possible complications
  - ❑ Damage to developing teeth
  - ❑ Abnormal position/ankylosis
  - ❑ Tooth loss
  - ❑ Pulp damage to injured or adjacent teeth
  - ❑ Other: _____
- ❑ Need for tetanus booster
- ❑ Injury prevention (eg, mouthguard)
- ❑ Follow up
- ❑ Referral: _____
- ❑ Other: _____