DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
7700 ARLINGTON BOULEVARD
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IN REPLY REFER TO
BUMEDINST 6600.19A
BUMED-M3
25 Feb 2022

BUMED INSTRUCTION 6600.19A

From: Chief, Bureau of Medicine and Surgery

Subj: DOCUMENTING DENTAL EXAMINATIONS IN ABSENCE OF ELECTRONIC DENTAL RECORDS

Ref: (a) DoD Instruction 6025.19 of 9 June 2014
(b) DoD Instruction 6040.45 of 16 November 2015
(c) SECNAVINST 6120.3A
(d) DHA PI 6040.10

Encl: (1) Instructions for Completing Navy Medicine Forms 6600/13, 6600/14, and 6600/15
(2) Sample Markings for Use on Navy Medicine Form 6600/15

1. Purpose. To issue guidance for completing NAVMED 6600/13 Dental Examination; NAVMED 6600/14 Dental Treatment; and NAVMED 6600/15 Current Status in absence of the electronic dental record. This instruction is a complete revision and should be reviewed in its entirety.

2. Cancellation. BUMEDINST 6600.19.

3. Scope and Applicability. This instruction applies to all budget submitting office 18 dental commands, units, and operational activities without access to electronic dental records.

4. Background. Per reference (a), Service members require an annual dental examination to determine dental classification status, which is a factor in assessing world-wide deployability. Documentation of the dental examination and subsequent treatment are currently being entered into an electronic dental record for primary use, and being printed for secondary use as hard copy records.

5. Policy and Procedures

a. Per references (b) and (c), dental providers at dental clinics and platforms lacking connectivity to electronic dental records must utilize NAVMED 6600/13; NAVMED 6600/14; and NAVMED 6600/15; or other Department of Defense (DoD) approved dental examination and treatment forms to record clinical documentation. The forensics section of the paper dental record must be completed. Procedures for completing these forms are found in enclosure (1) and an example illustration of markings used on NAVMED 6600/15 is found in enclosure (2).

b. When access to the electronic dental records is available, dental providers must follow the prescribed workflows for electronic capture of treatment described in reference (d), and dental providers will not utilize handwritten dental examination forms.

c. When a paper dental record is necessary for permanent change of station, transfer, or separation, the paper record will be populated with printed output from the electronic dental record.

d. If other DoD approved dental treatment forms (such as SF 603 Medical Record - Dental) are utilized to document dental treatment, the proper instructions for completion of those forms will be utilized.

e. When applicable, the paper and electronic records must be reconciled to include all treatment rendered to date. This process includes uploading documentation of care rendered in the operational environment into the electronic record when available, per reference (b).

6. Records Management

a. Records created as a result of this instruction, regardless of format or media, must be maintained and dispositioned per the records disposition schedules located on the Department of the Navy Directorate for Administration, Logistics, and Operations, Directives and Records Management Division portal page at https://portal.secnav.navy.mil/orgs/DUSNM/DONAA/DRM/Records-and-Information-Management/Approved%20Record%20Schedules/Forms/AllItems.aspx.

b. For questions concerning the management of records related to this instruction or the records disposition schedules, please contact the local records manager or the Department of the Navy Directorate for Administration, Logistics, and Operations, Directives and Records Management Division program office.

7. Review and Effective Date. Per OPNAVINST 5215.17A, Medical Operations (BUMED-M3) will review this instruction annually around the anniversary of its issuance date to ensure applicability, currency, and consistency with Federal, DoD, Secretary of the Navy, and Navy policy and statutory authority using OPNAV 5215/40 Review of Instruction. This instruction will be in effect for 10 years, unless revised or cancelled in the interim, and will be reissued by the 10-year anniversary date if it is still required, unless it meets one of the exceptions in OPNAVINST 5215.17A, paragraph 9. Otherwise, if the instruction is no longer required, it will be processed for cancellation as soon as the need for cancellation is known following the guidance in OPNAV Manual 5215.1 of May 2016.

8. Forms. These specialty forms are not authorized for local reproduction. They can be ordered from the Data Services Online Web site at https://dso.dla.mil.

a. NAVMED 6600/13 Dental Examination, SN 0105-LF-128-1500.

b. NAVMED 6600/14 Dental Treatment, SN 0105-LF-128-2700.

c. NAVMED 6600/15 Current Status, SN 0105-LF-128-3900.

G. D. SHAFFER
Acting

Releasability and distribution:
This instruction is cleared for public release and is available electronically only via the Navy Medicine Web site at, https://www.med.navy.mil/Directives

INSTRUCTIONS FOR COMPLETING NAVY MEDICINE FORMS 6600/13, 6600/14, AND 6600/15

1. General Comments

a. When access to the electronic dental record is not available, NAVMED 6600/13 Dental Examination may be used to document the periodic or annual recall dental examinations subsequent to initial accession. For purposes of medico-legal documentation, all entries on this form will be made in black ink, except as noted.

b. The front of NAVMED 6600/13 follows the Subjective, Objective, Assessment, and Plan (SOAP) note format of the examination. The form is designed so the examiner can comment on all areas required in a thorough examination. Negative findings will be documented where prompted. Expanded comments must be entered on the back of NAVMED 6600/13. Emergency, specialty consult examinations, and ongoing treatment which occur prior to the next annual examination will be documented on NAVMED 6600/14 Dental Treatment, accompanied by the appropriate update of the "Plan" section on the front of NAVMED 6600/13 and NAVMED 6600/15 Current Status, as applicable.

c. The Plan section of NAVMED 6600/13 has been designed so subparagraphs 1c(1) through 1c(6) information can be seen at a glance without sifting through numerous pages:

(1) Progress to date on completion of treatment plan.

(2) Next item on treatment plan to be completed.

(3) Portion of treatment plan not completed.

(4) Dental classification.

(5) Last dental examination date.

(6) Treatment needs for easy data entry into the current reporting data base.

2. Instructions for Completing the Front of NAVMED 6600/13

a. "S" (Subjective)

(1) Chief Complaint. Record any complaint in the patient's words. (The diagnosis is not made here but rather in the "A" section.)

(2) Age and Gender. Self-explanatory.

(3) Pain Level. If the patient reports pain, determine the pain level on a scale of 0-10.

Note. Use reverse side of NAVMED 6600/13 to describe pain and document a plan to address the pain, as needed.

(4) Current Tobacco Use. Self-explanatory. If "yes" document type, quantity, frequency, and duration on reverse side of NAVMED 6600/13.

b. "O" (Objective). This area of the form is used to record findings. The only exception is the caries section where the finding and diagnosis are considered the same.

(1) Health Questionnaire Review Findings. Circle within normal limits (WNL) or see dental health questionnaire (DHQ), as applicable. Reference DHQ to indicate medical findings which might affect dental treatment. Ensure these findings are properly documented on the DHQ.

(2) Medications Reviewed. Reviewing with the patient his or her current medications is an important process to help ensure patient safety during the treatment planning and execution phases. This block has been placed to remind providers to review any current medication information with the patient, and to proceed with any special medication management and safety process if required by command policy and current accreditation requirements.

(3) Blood Pressure. Measure and record.

(4) Radiographs Ordered. Check appropriate box(es) and write the tooth number(s) of the periapical radiograph(s) ordered. If no new radiographs have been ordered, it is permissible to write the dates of any previous radiographs that have been reviewed to support the current examination, followed by the abbreviation "rev" to indicate review.

(5) Radiographic Findings. Document any findings, including results from current radiographs and serial examinations.

(a) NAVMED 6600/13. Record all radiographic findings (except caries) in descriptive terms, mentioning size, location, and appearance.

(b) NAVMED 6600/15. In box 1, draw the findings in pencil. Radiolucent periradicular lesions are drawn with an outline; radiopaque periradicular lesions are drawn as a solid.

(6) Caries, Defective Restorations, and Fractured Teeth

(a) NAVMED 6600/13. Circle "None" or complete by writing in the tooth number and surfaces affected, (Example: #3 – mesio-occlusal (MO)).

(b) NAVMED 6600/15. In box 1, draw in pencil the anticipated appearance of the planned restoration. This is technically part of the "Plan" portion of the SOAP note, but is logically done at this time.

1. Amalgam restorations. Outline and block in.

2. Gold restorations. Outline and inscribe with diagonal lines within the outline.

3. Non-metallic restorations. Outline only. Do not block in or inscribe with diagonal lines.

4. Combination restorations. Outline the anticipated appearance, showing overall size, location, and shape. Indicate each portion according to type of material as outlined in subparagraphs 2b(6)(b)1 through 2b(6)(b)3.

(7) Incipient Lesions

(a) NAVMED 6600/13. For incipient caries write the tooth number and surfaces affected (Example: #5 – MO).

(b) NAVMED 6600/15. Incipient caries are NOT to be identified on the NAVMED 6600/15.

(8) Oral Cancer Screen and Soft Tissue. Document any positive findings here and on reverse side of the NAVMED 6600/13 if more space is needed. For negative findings, circle "WNL."

(9) Periodontal (Perio). Document any relevant findings. For negative findings, circle "WNL."

(10) Periodontal Screen and Recording (PSR) Score. Place the appropriate number in each of the 6 boxes of the grid. Use "Perio Findings" to explain any asterisks recorded.

(11) Endodontics (Endo). Document any relevant findings. For negative findings, circle "WNL."

(12) Temporomandibular Joint (TMJ). Document any relevant findings. For negative findings, circle "WNL."

(13) Occlusion. Document any relevant findings. For negative findings, circle "WNL."

(14) Oral Surgery. Annotate as needed. Third molar communications with the oral cavity will be noted as partial eruptions. For negative findings, circle "WNL."

(15) Other Findings. Use this section to explain other findings that do not fall into other listed categories. If none, circle "none."

c. "A" (Assessment). This section is generally used to make a diagnosis.

(1) Assessment of Chief Complaint. A diagnosis (differential or definitive) must be made and documented in this area if a chief complaint was recorded.

(2) Perio. Circle the appropriate condition.

(3) Endo

(a) NAVMED 6600/13. Indicate tooth number and diagnosis.

(b) NAVMED 6600/15. In box 1, indicate in pencil the indicated root canal treatment. As with the caries in the "O" section, this action is technically part of the plan, but is logically done at this point.

1. Root canal. Draw a line down the root or roots of teeth involved tracing the location of the root canal. If a periradicular lesion is present, outline approximate size, form, and location.

2. Apicoectomy. Draw a small triangle on the root of the tooth involved, apex away from the crown, the base line to show the approximate level of root amputation.

(4) Oral Surgery

(a) NAVMED 6600/13. Indicate tooth number and diagnosis.

(b) NAVMED 6600/15. Box 1.

1. Teeth recommended for extraction. Draw two parallel pencil lines through the tooth. Procedures treatment planned to restore function are drawn after teeth are removed.

2. Fractured tooth root. Indicate with a zigzag line on outline of tooth root.

3. Radiolucent lesions. Draw an outline of the approximate form and size in relative position on the dental chart. Do not block in.

(5) Other. Use this section for observations that do not fall into other listed categories.

(6) Risk Assessment Block. Categorize the patient's risk for developing caries, periodontal disease, and oral or oropharyngeal cancer, per BUMEDINST 6600.16B.

d. "P" (Treatment Plan). This section is comprised of the type of treatment, treatment needs (with urgent and routine sub-columns), and "Data Entry" columns. BUMEDINST 6600.18A provides the guidelines and criteria for determining dental readiness classification and urgency of treatment needs.

(1) SEQUENCE (Seq). This column assigns the "ideal" sequence, by type of treatment, over which the treatment is to occur. A number is placed in the column next to the appropriate type of treatment, accordingly. Ordinarily, "Urgent" treatment will have a higher priority than "Routine" treatment.

(2) DEPARTMENT AND TREATMENT NEEDS

(a) Oral Hygiene

1. If Oral prophylaxis, scaling, or root planing is to be part of the treatment plan, place the treatment plan sequence number in the appropriate Sequence Column of the corresponding phase (Urgent or Routine) column. For instance, if the root planning is Urgent and comes first in the plan, write a "1" in the Sequence block of the Urgent column.

2. Circle the desired provider level in either the Urgent or Routine sub column.

3. If a subsequent provider wishes to amend the treatment plan, line through the currently circled treatment and circle the desired treatment. The sequence number may also be changed by lining through the current number and writing in a new number. Document any changes to the initial treatment plan on NAVMED 6600/14.

4. In the Data Entry column, circle "1" for registered dental hygienist, "2"for prophy tech, or "3" for dental officer in the appropriate phase (Urgent or Routine) section. Leave blank if no treatment is indicated. Use pencil for the data entry.

5. Update both the Treatment Needs and Data Entry columns after each treatment session by doing one of these subparagraphs 2d(2)(a)5a through 2d(2)(a)5c:

(a) If another treatment session is desired by the same type provider, do not amend the notation in the Treatment Needs and Data Entry columns.

(b) If another treatment session is desired with a different type provider, line through the currently circled provider and circle the desired provider number in the Treatment Needs column. To change the data entry, erase the current pencil mark and circle the desired entry with pencil.

(c) If treatment is complete, line through the currently circled numbers in the Sequence and Treatment Needs column and erase the pencil mark in the Data Entry column.

(b) Sealants

1. NAVMED 6600/13: Write the teeth numbers (or letters) needing treatment. Complete remainder of section in the same way as the operative section.

2. NAVMED 6600/15: In box 1, write the letter "S" on the surface of tooth to be sealed.

(c) Operative

1. Place the treatment plan sequence number in the appropriate Sequence Block of the corresponding phase (Urgent or Routine) sub column.

2. Write the number(s) or letter(s) of teeth needing restoration in the appropriate Phase (Urgent or Routine) section of the Treatment Needs column. Leave blank if no treatment is indicated.

3. Class 3 (Urgent) operative treatment needs include, but are not limited to symptomatic operative treatment needs and carious lesions extending 1/3 of the way or greater into dentin. Teeth should be designated Urgent when the examination findings leave questions about whether they belong in the Urgent or Routine column.

4. If a specialty evaluation is required, write what needs to be evaluated next to the tooth number needing evaluation in the Treatment Needs column. (Example: Evaluation #3 for restorability.)

5. In the Data Entry column, circle the total number (not individual tooth numbers) of teeth needing treatment in each phase in pencil (Urgent or Routine). (Include in this number those teeth requiring evaluation.)

6. Subsequent examiners and providers can change the operative treatment plan by lining through the numbers written in the Treatment Needs column and writing in the tooth numbers or letters of the revised plan. Likewise, the Data Entry column must be changed by erasing the currently circled number and circling in pencil the revised number of teeth to be treated. The amender must fully document the changes to the treatment plan on NAVMED 6600/14. The amender must also update the pencil entries on NAVMED 6600/15.

7. After each treatment visit, update the Treatment Needs column by lining through the numbers or letters of teeth restored. Also update the Data Entry column by erasing

the currently circled number and circling in pencil the remaining number of teeth (not individual tooth numbers) needing restoration in each phase (Urgent or Routine). When treatment is complete, all numbers and letters in the Treatment Needs and Sequence columns will be lined through and in Data Entry column, all circled numbers will have been erased. After each treatment visit, update the pencil and ink entries on NAVMED 6600/15.

(d) Periodontics

1. At the time of examination, the provider will place the treatment plan sequence number in the appropriate Sequence column of the corresponding phase (Urgent or Routine) column. In the Consultation section of the Treatment Needs column, note if the patient needs either an urgent or routine periodontal evaluation and circle in pencil the "1" in the corresponding “Eval” Data Entry column. Write in a specific tooth, lesion, or area needing evaluation. (Example: Evaluate #27 area for mucogingival defect). Line through the Sequencing column number when the evaluation is complete.

2. The non-surgical and surgical categories in the Treatment Needs column will be completed by the provider providing the periodontal therapy. The periodontal provider will circle which quadrants require non-surgical urgent or routine therapy as appropriate in the ”Non-surgical” section of the Treatment Needs column. In a similar manner, the periodontal provider will annotate surgical needs in the surgical section. Changes are made as previously discussed. Line through quadrant numbers when treatment is complete.

3. In the non-surgical category Data Entry column circle in pencil the total number of quadrants requiring Urgent or Routine nonsurgical therapy as appropriate. In a similar manner complete the surgical category Data Entry column. When treatment is complete, all numbers in the Sequence and Treatment Needs will be lined through, and circles in Data Entry columns will have been erased.

(e) Oral Surgery

1. Place the treatment plan sequence number in the appropriate Sequence Block of the corresponding phase (Urgent or Routine) column. Line through the number when treatment is complete.

2. In the appropriate phase (Urgent or Routine) of the Treatment Need column, circle the 3rd molars to be extracted. Write in other teeth numbers or letters to be extracted and other treatment such as biopsy. If an evaluation is desired, write it down in the Consultation row of the appropriate Treatment Needs column (Example: Evaluate impacted #11 for extraction). Changes are made as in previous sections. Line through teeth numbers when treatment for those teeth is complete. After each treatment session, update the pencil and ink entries on NAVMED 6600/15.

3. The complexity envisioned in the extraction of teeth will guide whether the oral surgery treatment is planned as “simple” or “complex” (includes impacted tooth removal). See the Dental Procedure Codes definitions for detailed guidance.

4. In the Data Entry column, circle in pencil the total number of teeth (not individual teeth identification numbers) needing extraction in each phase (Urgent or Routine). After each treatment session, update this column by erasing the currently circled number and circling in pencil the number of teeth remaining to be extracted. Update the pencil and ink entries on NAVMED 6600/15. When all treatment is complete, all numbers in the Sequence and Treatment Needs will be lined through and all circles on the Data Entry column will have been erased.

(f) Endodontics

1. Place the treatment plan sequence number in the appropriate Sequence Block of the corresponding phase (Urgent or Routine) sub column. Line through the number when treatment is complete.

2. Write in the individual tooth identification numbers of teeth needing endodontic treatment, in either the Anterior or Posterior section of the Treatment Need column. Amend if necessary as described in previous paragraphs.

3. If an evaluation is required, write in the specific problem in the Consultation row of the Treatment Needs, Urgent sub column. (Example: Evaluate vitality #14).

4. In the Data Entry column, circle in pencil the total number of teeth (not individual teeth identification numbers) needing treatment in either Urgent or Routine, including teeth needing an evaluation. Update Treatment Needs and Data Entry columns after each treatment session. Update NAVMED 6600/15 when treatment for each tooth is complete.

(g) Prosthodontics

1. Place the treatment plan sequence number in the appropriate Sequence Column of the corresponding phase (Urgent or Routine) sub column. Line through the number when treatment is complete.

2. In the appropriate Treatment Needs sub column, write in the individual teeth.

3. If an evaluation is needed, write the specifics in the Consultation row of Treatment Needs column. (Example: Evaluate margins, crown # 8 - redo?).

4. In the appropriate phase (Urgent or Routine) of the Data Entry column, circle in pencil the total number of units of fixed required. For removable, circle the number of appliances needed. Update treatment needs and Data Entry sections after each treatment session. Update NAVMED 6600/15 using the markings in subparagraphs 2d(2)(g)4a through 2d(2)(g)4e:

a. Non-metallic crowns, facings and pontics: Outline each aspect of the crown.

b. Gold and other cast metallic crowns and pontics: Outline and inscribe diagonal lines within the outline.

c. Fixed partial dentures: Draw a horizontal line connecting the retainer(s) and pontic(s).

d. Removable appliances: Place a line over numbers of the teeth to be replaced (Box 1) or teeth replaced (Box 2).

e. Porcelain crown with post: Outline each aspect of the crown; outline and block in approximate size and position of the post or posts.

(h) Other

1. Place the treatment plan sequence number in the appropriate Sequence Block of the corresponding phase (Urgent or Routine) column. Place a line through the number when treatment is complete.

2. In the Treatment Needs column, write in narrative form the action desired. Examples of treatment classified as "Other" for these purposes include oral diagnosis and medicine, orofacial pain, and orthodontics.

3. If changes are made, line through original treatment and write in the change, documenting on NAVMED 6600/14.

4. In the Data Entry column, circle in pencil the number "1" in the appropriate Phase (Urgent or Routine) sub column.

5. When treatment is complete, all entries in the Treatment Needs column are lined through, and the circle in the Data Entry column will have been erased.

(i) Caries Risk Management. Based on the Risk Assessment in the "A" section of this form, document if a high or moderate caries risk protocol is indicated by checking the appropriate box and then write the individualized caries risk plan that will meet this patient's needs. Refer to BUMEDINST 6600.16B for details on the most current or best accepted caries risk treatment modalities, as required.

(j) Additional Remarks. All documentation of this type should be placed in the space provided. Additional information should be written on the reverse side of NAVMED 6600/13.

(k) Patient counseled today regarding the health hazards associated with tobacco use and where to seek cessation assistance: Patients who use tobacco must be counseled regarding the health hazards associated with tobacco use and where to seek cessation assistance. Place an "X" in the block when this information has been delivered. If the patient does not use tobacco, circle the "N/A" entry.

(l) Patient has been advised of the findings of this examination and has verbalized or demonstrated understanding. It is important that patients are fully apprised of the results of the dental examination and the recommended treatment. When this information has been delivered, and in the examining doctor's opinion, the patient has demonstrated an understanding, check the applicable box to affirm and document.

(3) DATA ENTRY. Treatment needs are entered into the current reporting data base for department, clinic, command, or Bureau of Medicine and Surgery use. The numbers in this column are the sum total of numbers of teeth, quadrants, or units to be treated rather than individual tooth, quadrant, or unit identification numbers. Only one number is circled at a time in each department row. The column is updated after each patient visit by erasing the currently circled number and circling another appropriate number. For example, a patient had three Urgent lesions at the beginning of an operative appointment, and one lesion was restored during the appointment. At the end of the appointment, in the Urgent Data Entry column of Operative, the circle around "3" would be erased and the "2" would be circled. When treatment is complete, no number is circled. For periodontal screening and recording data entry, circle the highest sextant score obtained (one entry only).

(4) SIGNATURE BOX. Places for signature, clinic, date, and name stamp of dentist completing the examination.

(5) DATE TREATMENT COMPLETED BOX. When the treatment plan has been fully completed, this box will be completed with the date, provider's signature, name stamp, and clinic. In contrast with previous treatment plan completion, a new annual examination is not indicated.

(6) DENTAL CLASSIFICATION (CLASS). Circle the appropriate number in pencil. When the class changes, erase the currently circled number and circle the new class number in pencil.

3. Instructions for Completing the Back of NAVMED 6600/13

a. The back of NAVMED 6600/13 is provided for recording narrative comments associated with the dental examination. NAVMED 6600/14 is used for related consultation, and to document treatment provided in the execution of the Treatment Plan.

b. For placement in the Dental Record, NAVMED 6600/13 is placed with the Plan or "P" side facing up, on the backside of the middle page of the Dental Record Jacket opposite the NAVMED 6600/15. NAVMED 6600/13 will be in chronological order, with the most recent examination on top.

c. NAVMED 6600/14, SF 603, SF 603A Medical Record – Dental – Continuation, and other associated forms are located on the opposite page, in chronological order with most recent on top.

d. NAVMED 6600/15 or the most recent odontogram always remains on top of these forms, opposite NAVMED 6600/13.

4. Instructions for Completing the Forensics Section of the Dental Record Jacket

a. This section is printed directly on the inside of the back cover of the dental record jacket.

b. It is intended that this section will be completed only once (usually at accession) during the member's Service career and whenever substantial changes in the parameters used in forensic identification are made. If a replacement record is made, a new forensic examination must be completed.

c. All entries are made in black ink.

d. The teeth are separated on the odontogram to facilitate illustrating supernumerary teeth, mixed dentition, and interproximal restorations.

(1) If a restoration exists interproximally with no occlusal component, use the space to draw the restoration.

(2) When indicating fixed partial dentures, ignore the spaces. Draw the prosthesis and indicate the materials and teeth involved in the remarks section.

e. Remarks. Use this section to indicate restorative materials and differentiate between sealants, composites, and temporaries.

f. Soft Tissue Remarks. Partial list of the more common non-pathologic findings to facilitate charting. For each condition, indicate approximate size or extent and location. Leave blank if normal.

g. Occlusion

(1) Angle's Class: I, II, or III. Each side may be different.

(2) Overjet and Overbite: Indicate in millimeters; leave blank if normal.

(3) Crossbite: Indicate teeth involved.

h. Hard Tissue Remarks. Partial listing of the more common non-pathologic findings to facilitate charting. Leave blank if normal.

(1) Intrinsic Staining: Indicate teeth involved. Check tetracycline, if appropriate.

(2) Tori: Indicate location and approximate size.

(3) Rotated Teeth: Indicate teeth involved and approximate number of degrees to the nearest 45 degrees.

(4) Malposed Teeth: Indicate teeth involved and whether facio- or linguo- version.

i. Doctor's Name Stamp, Signature, Patient Identification Blocks: Complete as indicated.

5. Instructions for Completing the NAVMED 6600/15

a. NAVMED 6600/15 contains the odontogram, or visual representation, of accession and subsequent diseases and abnormalities, missing teeth, and planned and completed dental treatment.

b. Box 1, Accession and Subsequent Diseases and Abnormalities:

(1) All carious lesions, indications for extraction, indications for root canal treatment, and periradicular lesions are drawn in pencil.

(2) When the indicated treatment is completed, the pencil entry is erased and completed treatment is diagramed in Box 2.

c. Box 2, Missing Teeth at Time of Accession and Treatments Completed After Accession:

(1) This box is filled out in black ink. Otherwise, size, shape, and location of markings are the same as indicated for Box 1.

(2) All information, including extractions, restorations and root canal treatment, is cumulative for the dates indicated on the form.

(3) Missing teeth from the accession examination are also included in this box. All missing teeth are indicated by drawing a large "X" on the root or roots.

(4) When indicating fixed partial dentures, ignore the spaces and draw the prosthesis on each tooth as usual.

(5) Additional markings:

(a) Edentulous Mouth: Inscribe crossing lines, one extending from the maxillary right third molar to the mandibular left third molar and the other from the maxillary left third molar to the mandibular right third molar.

(b) Edentulous Arch: Make crossing lines each running from the uppermost aspect of one third molar to the lowermost aspect of the third molar on the opposite side.

(c) Temporary restorations: Outline the restoration showing size, location, and shape. Indicate the date placed and material used on the NAVMED 6600/14.

(d) Partially erupted tooth: In the diagram of the tooth, draw an arcing line through the long axis.

(e) Impacted teeth: Outline all aspects of each impacted tooth with a single oval. The long axis of the tooth should be indicated by an arrow pointing in the direction of the crown.

(f) Drifted teeth: Draw an arrow at the designating number of the tooth that has moved, with the point of the arrow indicating the direction of movement.

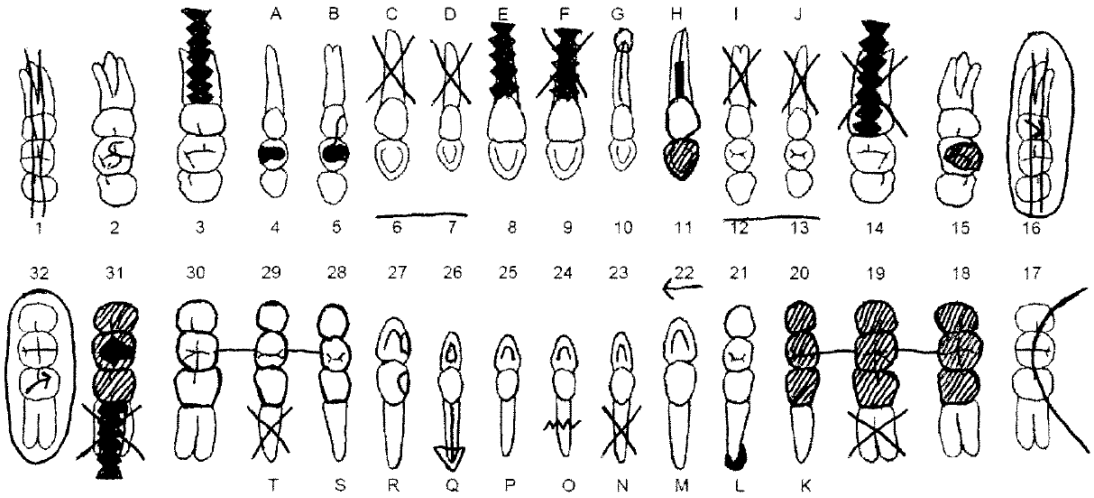
(g) Implants replacing single rooted teeth: Draw wavy lines over the outline of the root structure and extend a few millimeters beyond the apex to represent the general shape of an implant screw. Block in.

(h) Implants replacing multi-rooted teeth: Draw wavy lines through the center of the root structure and extend a few millimeters beyond the apex to represent the general shape of an implant screw. Block in.

d. Box 3, Medical Alert: The medical alert is placed on this form since it is readily viewable by all clinicians when opening the record. If a medical alert exists, the word "ALERT" is written or stamped in large red letters with a brief explanation.

e. Box 4, Patient Identification: Complete as indicated.

SAMPLE MARKINGS FOR USE ON NAVY MEDICINE FORM 6600/15



Key to Sample markings for use on NAVMED 6600/15, Current Status

Note: Markings are the same for Box 1 (treatment planned) and Box 2 (treatment completed) unless otherwise noted.

Tooth 1 – tooth treatment planned for an extraction (Box 1 only)
Tooth 2 – sealant
Tooth 3 – planned implant for a multi-rooted tooth (Box 1 only)
Tooth 4 – amalgam restoration
Tooth 5 – combination restoration MO amalgam restoration, mesio-buccal (MB) composite restoration)
Teeth 6, 7, 9, 12, 13, 14, 19, 23, 29, and 31 – missing teeth (Box 2 only)
Teeth 6, 7, 12, and 13 – removable appliances
Tooth 8 – planned implant for a single rooted tooth (Box 1 only)
Tooth 9 – implant completed on a single-rooted tooth (Box 2 only)
Tooth 10 – root canal with radiolucent periradicular lesion
Tooth 11 – porcelain fused to metal crown with post and root canal
Tooth 14 – implant completed on a multi-rooted tooth (Box 2 only)
Tooth 15 – gold restoration
Tooth 16 – impacted and treatment planned for a distoangular extraction (Box 1 only)
Tooth 17 – partially erupted tooth
Teeth 18-20 – fixed partial denture (gold or other metallic crowns and pontic)
Tooth 21 – radiopaque periradicular lesion
Tooth 22 – drifted tooth

Tooth 24 – fractured tooth root
Tooth 26 – apicoectomy with root canal and non-metallic restoration
Tooth 27 – non-metallic restoration (composite, porcelain, or glass ionomer)
Teeth 28-30 – fixed partial denture (non-metallic crowns and pontic)
Tooth 31 – example of multiple procedures (amalgam, root canal, gold crown, extraction, and implant) performed on the same tooth over an extended period of time (Box 2 only)
Tooth 32 – mesioangular impacted tooth