ORAL HEALTH CENTRE OF WESTERN AUSTRALIA	**Form 23** **Patient Management Plan**	**Use Patient Barcode Label** Given Name _____ Surname _____ DOB _____ TEMP _____

Clinician:	Clinician ID:	Date:

Management Priorities:

- Relief of pain
- Address the reason for attendance/presenting complaint (Form 21)
- Life threatening problems (e.g. OM, OP, OS, infections)
- Inflammatory conditions (e.g. Endo, Perio, OS, infections.)
- Caries management (includes prevention and restorations)
- Assessment and replacement of restorations for non-carious reasons (e.g. fracture, aesthetics)
- Reassessment
- Repositioning (orthodontics if required)
- Prosthodontics (indirect restorations, dentures, implants, splints)
- Review, reassessment and ongoing care (includes regular debridement, follow-up of endodontic and prosthodontic treatment)

PMP to include:

- Order of procedures (tooth by tooth) according to priority
- Appointment outline – time, procedure, proposed date
- Further investigations/referrals required

Relief of Pain

Supervisor's signature for palliative treatment by student:_____ Clinician Code: _____

Address the reason for attendance/presenting complaint (Form 21)

Life threatening problems (e.g. OM, OP, OS, infections)

Inflammatory conditions (e.g. Endo, Perio, OS, infections)

Do not write within this shaded area

Form 23

Form 23 Patient Management Plan *continuation*

Form 23

Caries management (includes prevention and restorations)

Assessment and replacement of restorations for non-carious reasons (e.g. fracture, aesthetics)

Reassessment

Repositioning (orthodontics if required)

Prosthodontics (indirect restorations, dentures, implants, splints)

Review, reassessment and ongoing care (includes regular debridement, follow-up of endodontic and prosthodontic treatment)

Patient Management Plan Authorised by: (for student clinicians)	Clinician ID:	Date:

I understand and agree to the suggested treatment plan		
Parent/Guardian Signature:	Parent/Guardian Name:	Date:

Do not write within this shaded area