

EAO Certificate in Implant- based Therapy

**Standardised
documentation for
implant treatment**

Introduction

This document enables applicants for the EAO Certification Programme to submit their six case presentations electronically.

You must complete all mandatory fields and adhere to the requirements of each field. Please ensure that the information gives the best representation of your skills and management of the case.

Please follow the template and work through all pages. In addition, you will need to supply photos to support your application. You can download guidance notes and example photos by following [this link](#).

Instructions continue on the next page. Use the buttons at the top of each page to move through the document.

For any questions regarding this application form, please contact the EAO Office at
T +33 1 42 36 62 20 | **E** info@eao.org

Introduction

Please save a blank copy of this document on your computer.

Make a copy for each case you will present to the Certification Programme committee. Only after saving the PDF on your computer will you be able to fill it in with information about the patient. Please use **Adobe Reader** (not Preview) to avoid any inconvenience.

The PDF works best when viewed in full screen mode. You can exit full screen mode at any stage by pressing 'escape'. You can return to full screen mode by pressing *Ctrl+L* (PC) or *Command+L* (Mac).

You can save your progress at any time by pressing *Ctrl/Command+S*. Reopen the saved document to continue working on it.

To download the most recent version of Adobe Reader, visit <https://get.adobe.com/uk/reader/>

You can view example case studies [here](#).

When finished, upload your document to the EAO website, as well as the necessary photos to support your case study. Full details about how to upload to the EAO website are available in the terms and conditions sheet.

Patient information

Fill out each box relating to the patient

Case number

Initials

Age

Profession

Patient expectations, main objectives and aesthetic goals

General remarks

Patient information

Medical history

Has the patient ever suffered from any of the following conditions?

	Yes	No	Details
1. Infectious diseases (e.g. HIV, hepatitis)	<input type="checkbox"/>	<input type="checkbox"/>	
2. Cardiovascular disease	<input type="checkbox"/>	<input type="checkbox"/>	
3. Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>	
4. Metabolic disease	<input type="checkbox"/>	<input type="checkbox"/>	
5. Allergies	<input type="checkbox"/>	<input type="checkbox"/>	
6. Rheumatic disease	<input type="checkbox"/>	<input type="checkbox"/>	
7. Psychological/psychiatric disease	<input type="checkbox"/>	<input type="checkbox"/>	
8. Smoker? If yes, how much?	<input type="checkbox"/>	<input type="checkbox"/>	
9. Units of alcohol per day	<input type="checkbox"/>	<input type="checkbox"/>	
10. Prescribed medications (please detail)	<input type="checkbox"/>	<input type="checkbox"/>	
11. Other diseases (e.g. cancer); please give details	<input type="checkbox"/>	<input type="checkbox"/>	



Answer each question 'Yes' or 'No' by clicking the appropriate box.

Type any details necessary into the adjacent 'Details' box.

Patient information

TMJD questionnaire

	No	Yes *
1. Jaw problems when chewing	<input type="checkbox"/>	<input type="checkbox"/>
2. Jaw problems when talking	<input type="checkbox"/>	<input type="checkbox"/>
3. Problems in closing teeth properly	<input type="checkbox"/>	<input type="checkbox"/>
4. Problems when opening mouth very wide	<input type="checkbox"/>	<input type="checkbox"/>
5. Jaw joints make noise	<input type="checkbox"/>	<input type="checkbox"/>
6. Previous pain in the area of jaw joints	<input type="checkbox"/>	<input type="checkbox"/>
7. Headaches	<input type="checkbox"/>	<input type="checkbox"/>
8. Cramps or spasm in head or neck	<input type="checkbox"/>	<input type="checkbox"/>
9. General problems with posture	<input type="checkbox"/>	<input type="checkbox"/>
10. Grinding or clenching teeth	<input type="checkbox"/>	<input type="checkbox"/>



* If yes, please use the following scale:

- 1. Slight pain – analgesics not required
- 2. Moderate pain – analgesics required
- 3. Severe pain with severe impact on quality of life

Extra oral examination

	Correct	Incorrect	Details
Vertical dimension			
Profile			
Upper incisal edges/upper lip			
Lower incisal edges/lower lip			

	Low	Average	High
Upper lip: smile line			
Remarks			

TMJD examination

Comparative palpation

	Left	Right
Lateral pole, static		
Lateral pole, on opening		
Posterior joint space		
Crepitation (noise)		
Muscle of mastication tenderness?		

Clicking

	Left	Right
Reciprocal clicking		
Clicking on wide opening		
Other clicking or noise		



Range of options:
- / + / ++ / +++

Pre-operative assessment: tooth mobility/sensitivity

Date:

Mobility																
Percussion																
Vitality																
Tooth number	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
				55	54	53	52	51	61	62	63	64	65			
				85	84	83	82	81	71	72	73	74	75			
Tooth number	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
Vitality																
Percussion																
Mobility																



Tooth mobility graded 1–3 using Miller’s Index:

- 1. Up to 1 mm of movement in a horizontal direction
- 2. Greater than 1 mm of movement in a horizontal direction
- 3. Excessive horizontal and vertical movement

Pain with percussion marked with ‘X’

Vitality marked ‘+’ or ‘-’

Pre-operative assessment: periodontal status



Plaque:
– (no) or + (yes)

Bleeding on probing:
– (no) or + (yes)

Pocket depth: record
the depth in millimetres

Date:

Plaque	labial	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	
	lingual	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	
Bleeding on probing	labial	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	
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Single tooth prognosis

	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
Hopeless prognosis																
Uncertain prognosis																
Good prognosis																
Good prognosis																
Uncertain prognosis																
Hopeless prognosis																
	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38



Mark tooth in the matching category with X. Leave a gap when a tooth is missing.

Good prognosis

A 'good' tooth is one that is expected to be retained in the long term provided adequate treatment, and where complications are not expected.

A tooth that was previously 'doubtful' can become "good" if a maintainable situation has been achieved and no further treatment is required.

Uncertain prognosis

Periodontal criteria

- furcation involvement
- extensive vertical bone loss
- extensive horizontal bone loss

Endodontic criteria

- incomplete root filling and retreatment perhaps impossible
- periapical lesion
- large posts/screws

Tooth substance criteria

- root caries
- perhaps non-restorable

Hopeless prognosis

Periodontal criteria

- recurrent periodontal abscesses
- perio-endo lesion (periodontal origin), not treatable
- loss of attachment to the apex

Endodontic criteria

- accidental perforation of the root inappropriate for endodontic treatment or re-treatment

Tooth substance criteria

- vertical root fracture
- horizontal root fracture extensive root caries

Other reasons

- functional reasons (non-functional)

Treatment plan summary

Treatment options considered with patient

Advantages

Disadvantages



If there is more than one treatment option, explain the advantages and disadvantages of each.

List the components of the treatment plan in order of priority

Informed consent

Has the patient been informed of possible complications for this treatment?

Has the patient been informed of the long-term outcome?

Has the patient been informed about other treatment options?

Has the patient given informed consent?

No	Yes
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>



Answer each question 'yes' or 'no' by clicking the appropriate box.

Summary of treatment carried out



Give a description of the treatment carried out at each visit (e.g. abstract)

- avoid excessive detail
- minimum 100 words, maximum 200 words
- include dates

Summary of any complications arising



Provide a summary of any difficulties or complications arising from treatment.

Please provide dates and a description how the difficulties and complications were handled.

Periodontal status at least six months post-treatment



Plaque:
– (no) or + (yes)

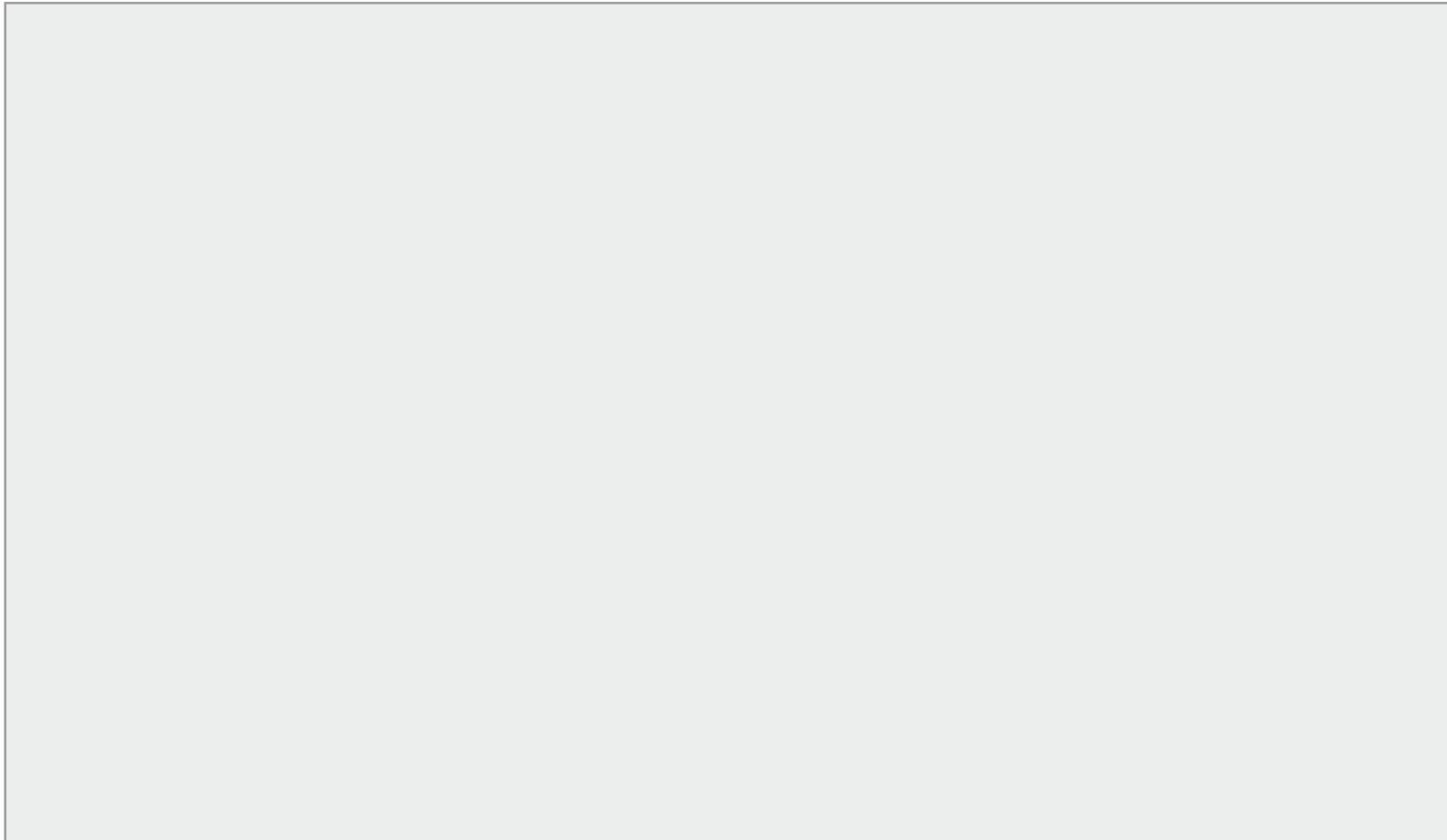
Bleeding on probing:
– (no) or + (yes)

Pocket depth: record
the depth in millimetres

Date:

Plaque	labial	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	<div></div>	
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Reflective summary



Give a short comment reflecting on this treatment.

- were the patient expectations fulfilled?
- would you have carried out any aspect of the treatment differently?
- how might this have affected the outcome?

Note: It is fine to use a case that is not perfect and reflect on the method and lessons learned.

Your contact details

Name	<input type="text"/>
Postal address	<input type="text"/>
Email address	<input type="text"/>
Phone number	<input type="text"/>



When you have completed all your responses, upload this PDF online through the EAO website. See the terms and conditions page for more details.