

1. **Review the Medical history to see if any changes have occurred since their last visit** and ask the following questions:
  - a. Any new medications, or changes in medications
  - b. Any recent hospitalizations
  - c. Any new allergies
  - d. Are you currently under the care of a doctor
2. It is not necessary to retake blood pressure and pulse unless the person:
  - a. Is a known hypertensive
  - b. Had an elevated reading at the initial appointment
  - c. Has a history of cardiac disease
3. **Perform a visual intra-oral inspection** to see if any viral or aphthous ulcers or tissue trauma is evident.
4. **Re-evaluate the area previously scaled for tissue response and residual calculus** and compose statements to be entered on clinical worksheet.
5. **Ask patient** if they have tried to incorporate your oral hygiene instructions into their oral homecare routine.
6. **Ask faculty for check-in.**
7. After check-in, **disclose patient and perform a new plaque index** making suggestions based upon the plaque score. Involve patient.
8. Upon completion of **oral hygiene instruction** continue patient treatment according to treatment plan.

#### REVISIT Appointment chart entry

1. **Statement about the medical history review.**
2. **Statement about blood pressure if retaken.**
3. **Statement about intra oral inspection, if there are findings.**
4. **Statement about gingival tissue response to scaling.**
5. **Plaque score and oral hygiene instruction provided.**
6. **Treatment provided at today's visit.**

**Always include evaluation of previously scaled areas on revisits. Document on clinical worksheet any changes noted, positive and negative**

  - a. **Decreased bleeding**
  - b. **Decreased inflammation**
  - c. **Improved plaque score**
  - d. **Patient comments about previous treatment**
  - e. **No significant improvement**
7. If treatment is completed this visit, **statement about referral if needed and recommended recall date.**