Systems for Dentists

# Clinician Guide to SFD



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# Clinicians Guide

### **Patient**

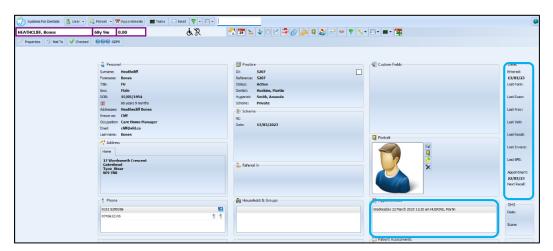
# Searching for a Patient Record

To open a patient record from the appointment page, **double click on the next appointment** in your diary.



#### Patient Record

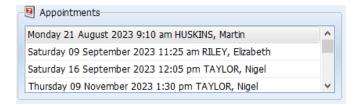
On the patient record home screen, you can see personal information as well as important dates and future appointments for reference. You can double click on any heading to open the properties window.



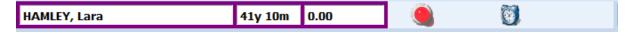


The dates section shows important date such as: Entered (when they joined), last form, last exam, last x-ray, last visit, last recall, last invoice, last BPE, Appointment (next appointment) and next recall.

The appointments section shows future appointments that are booked for the patient.



On the patient tool bar, you will see the patient's name, followed by their age and their account balance. The colour surrounding the information indicates the patient scheme. The alerts box will display patient flags which are patient key indicators (customisable).



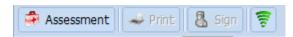
Note: You can change any of these if not already done by the reception by double clicking on the necessary box of information, correcting any details and clicking OK.

#### **Medical Assessment**

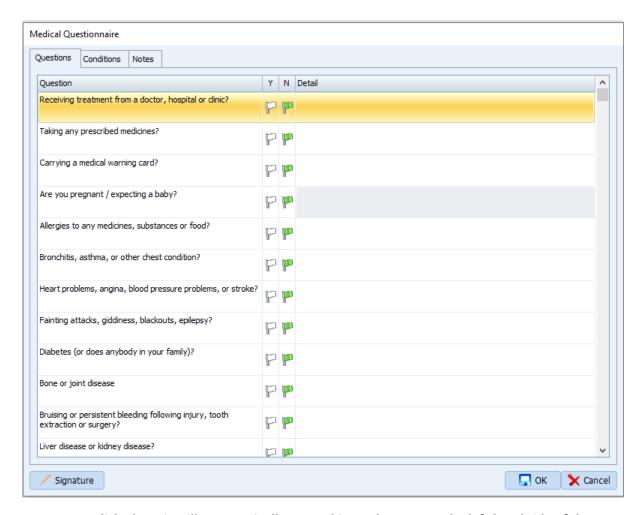
To complete a medical assessment, click the first aid box icon.



On the medical toolbar, click 'Assessment'.



You can choose Y (yes) or N (no) or alternatively if all answers are no, just click the 'N' above the flags.



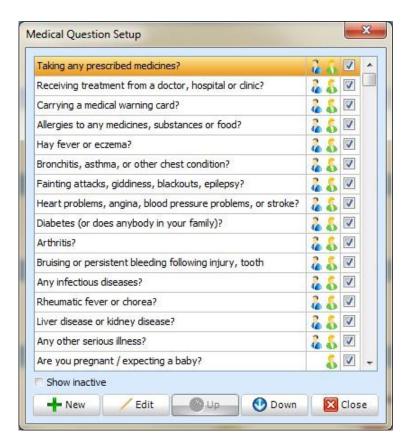
Note: Once clicked OK, it will automatically save. This can be seen on the left-hand side of the medical screen.

To access the Questions setup, click on the **Tooth icon** at the top left and select **Setup**. From there click on the **Questions** button, which is located under the **Medical Bar**.



The **Medical Questions Setup window** will now appear showing you a list of all the current active questions.

To add a new question or change an existing one click on the **New** or **Edit** buttons.



The Medical Questions Properties window appears for both options.

Enter the question which you would like to create in the **Question** textbox. Next select which gender(s) the question should be asked to by clicking on the drop-down menu.





The required checkbox is there in case a question needs more information from the patient, such as "Taking any prescribed medicine" the practice will possibly want to know which medicines and for what condition. So, to activate this field, click on the **Required** checkbox, and in the question textbox type in the additional question(s).

Click **Save** to save your changes.

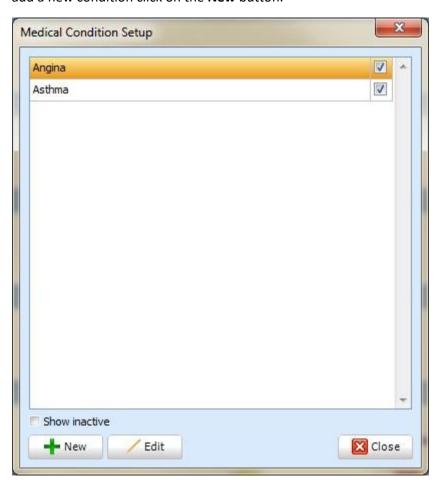
Within the Medical History Questionnaires, there is a conditions tab, which lists conditions such as Asthma or Angina. To complete the questionnaire the patient will look through these conditions and tick which he or she has.

To access the **Conditions** setup, click on the **Tooth icon at the top left** and select **setup**. From there click on the **Conditions** button.



You will see the current conditions which appears on the medical assessment screen under the conditions tab.

To change an existing condition, highlight the one you want and click on the **Edit** button or to add a new condition click on the **New** button.



Within the 'Name' textbox, type in the name of the condition and click Save.

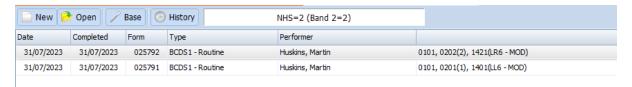


#### **Treatment**

#### **Treatment Forms**

When clicking the dentist chair icon. It will take you to the treatment section. This will display previous treatment forms.

To open an old treatment form, just double click on the desired form and this will open it for you.



To create a new treatment form, click **New** in the top left-hand corner.



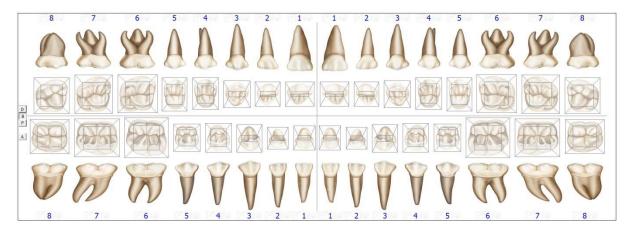
You will be presented with the **New Treatment Course** window below.

General	
Performer:	RILEY, Elizabeth
Scheme:	NHS ▼
Date:	20/11/2012 🔻
NHS	
Category:	Routine Treatment ▼
Contract:	•
Exemption	
Туре:	(none) 🔻
	Evidence HAS been seen
	0.00
	☐ Save ★ Cancel

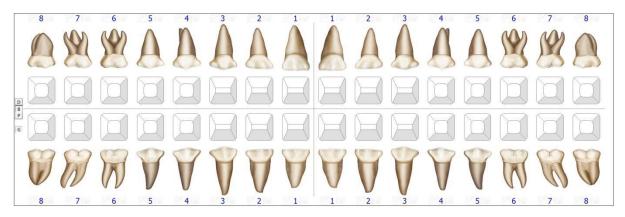


By clicking **D** you will be presented with any deciduous teeth a patient may have. By clicking **P** you will see the patient's permanent teeth. **B** displays both deciduous and permanent teeth.

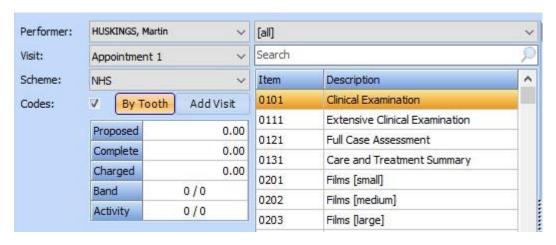
Also note that by clicking **A**, this will present the chart in anatomical mode.



If you click **G**, the chart will be presented in graphical mode.



By default, the form opens in the **Treatment** tab.



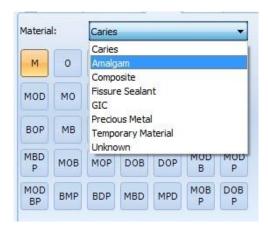
This tab displays the performer, visits and scheme. For NHS forms, the proposed, completed, charged, band and activity columns update as various treatment items are added and completed.

By having the checkbox adjacent to **Codes** checked, the list of treatment items will be visible (shown above).



You also have the ability to add visits (appointments) from this tab. This option is useful if the patient comes in for an initial exam but needs to return for further treatment.

There are a few methods available for adding fillings to the base chart. In the bottom left hand side of the base chart screen you will see all of your fillings options.



If you wanted to add a mesial filling to the chart, click on **M** from the fillings options. By clicking on **M** this will activate the **Material** dropdown list.

Once you have selected the material from the dropdown, click on the tooth on the chart you wish to add the filling to.

The following is an example of an amalgam mesial filling, shown in the **graphical** mode.





The following is an example of an amalgam mesial filling, shown in the **anatomical** mode.



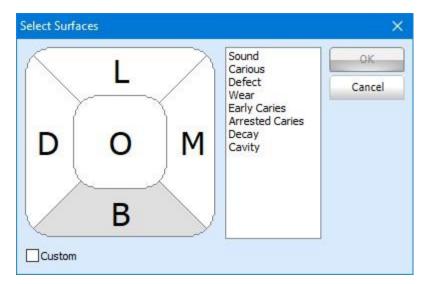


You would repeat this process for any other fillings you wish to add to the base chart.

Alternatively for fillings, you can use the Filling button.



Click the **Filling** button and select the material then click on the tooth you wish to add the filling to. You will be presented with the screen below.



Click on the surfaces you wish to add the filling to, areas you select will be presented in green, so in the example above the patient has had an MOD filling.





It is as easy to add other treatment items to the base chart as it is to add fillings. For example to add a crown, click on the **Crown** button from the menu, choose the material from the dropdown, then select the tooth from the chart that the crown needs to be added to (process shown below).



**Tip:** To remove anything from the base chart that may have been added by mistake click on the Clear button from the menu then click on the tooth the treatment item is to be removed from.



Observations can also be added to the base charts such a fracture, impacted or worn. Select from the menu and click on the affected area of the tooth (example below).



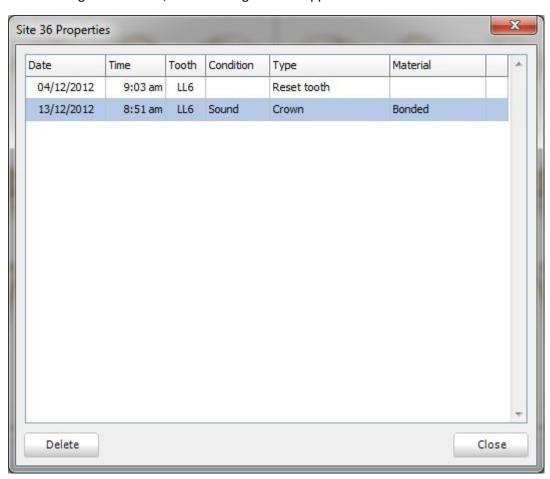


The example above shows a fracture on the lower right 6.

**Tip:** To see anything that has been added to a particular tooth, click the properties button then click on appropriate tooth (example below).



After clicking on the tooth, the following window appears.



There also is a **Delete** button in this window. To remove anything added in error highlight the item that needs removed by clicking on it, then click the **Delete** button in the bottom left of the screen.



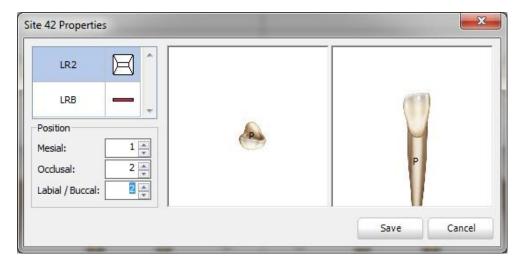
On the base chart it is also possible to add any movement that may have occurred to a particular tooth. Click the **Movement** button from the menu and select the tooth from the chart you wish to add movement to.



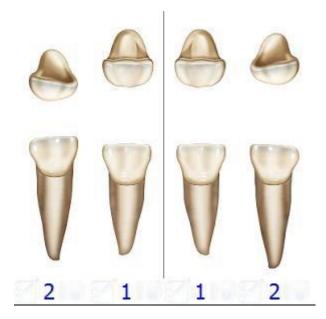
After clicking **Movement** the following window appears.



In this particular example you can see it's on the LR2 and the LRB is not present (indicated by red horizontal line). From the **Position** section of this window there is the ability to add Mesial, Occlusal, and Labial / Buccal movement. The tooth will physically move within this window as the values are updated.



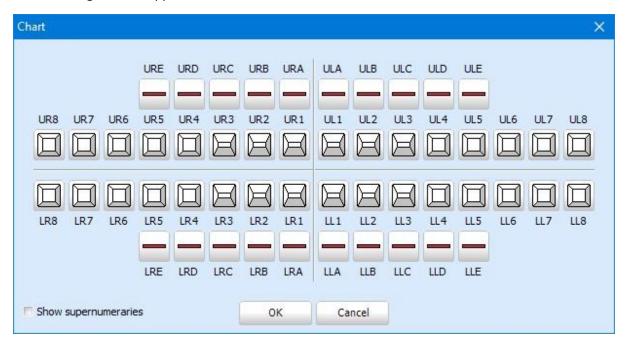
Click the **Save** button once you are happy with the values recorded. Notice that this tooth's position has moved appropriately on the base chart.



From the base chart it is important to state the layout of teeth, stating any deciduous and permanent teeth a patient may have. Click on the layout button to do this.



The following window appears.



The vertical red line shows that the tooth is not present. Therefore in the example above the patient has a full set of permanent teeth and the deciduous teeth are no longer present.

To change the current state of a tooth, click on the icon and the following menu appears. In our first example we are going to mark a tooth as missing.



You have the option to mark the tooth as Un-erupted, Partially-erupted, missing, Retained Root, and Closed Gap. To mark the tooth as missing, click on the **vertical red line**. On the layout screen it is now shown as missing.



Click **OK** on the Layout window. You will now see that the tooth is now longer present on the base chart.

Partially erupted teeth are common in children, to add this to the base chart follow the steps below.

Firstly, click on the layout button from the base chart menu. Then click on the tooth that is partially erupted.

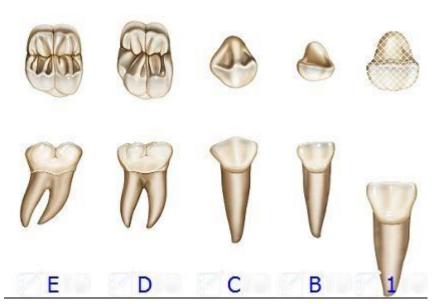
In this example the patient has lost their LRA and their LR1 is partially erupted. First of all click on the LRA and mark it as missing.



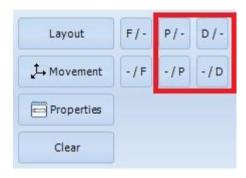
Then we can mark the LR1 as Partially Erupted.



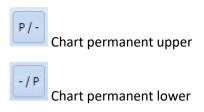
Click **OK** on the layout screen you will now see the partially erupted LR1 on the patient's base chart.



**Tip:** To save time you can chart the full upper or the full lower jaws as permanent / deciduous by one click of a button. These buttons are towards the far right of the base chart menu.



The various buttons do the following:



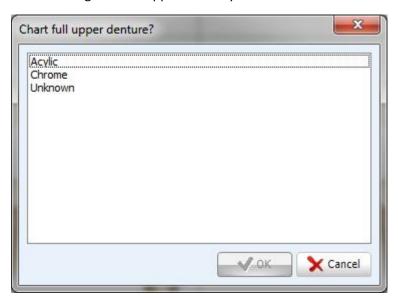


- Chart deciduous upper
- Chart deciduous lower

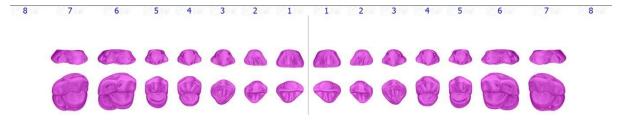
You also have the ability to chart full lower/upper dentures.

- Chart full upper denture
- Chart full lower denture

The following window appears once you have clicked on one of these buttons.

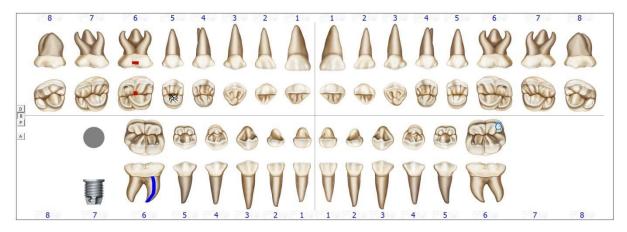


Choose your material for the denture from the list and click ok. Once you click ok, this will apply the denture to the base chart.

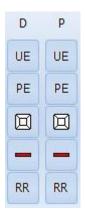


**Tip:** To add a material for a denture, refer to the Setup section of the manual.

Below is an example base chart.

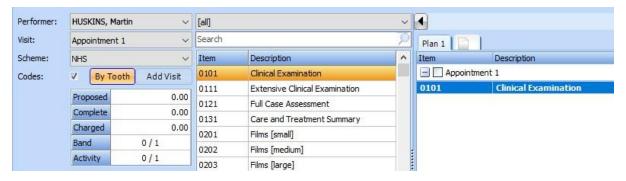


You can also you use the buttons shown below to change the layout within the base chart.

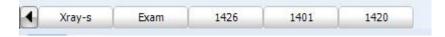


**D** stands for deciduous and **P** for permanent. To mark one of these options on the base chart, click on the desired button then click on the tooth on the chart.

The most common treatment item is a clinical examination. Once you have opened a new treatment form, double click on 'Clinical Examination'.



**Tip:** To make the process even quicker you can set quick codes so that you can add frequently used treatment items to a treatment form at the click of a button (quick code bar shown below).



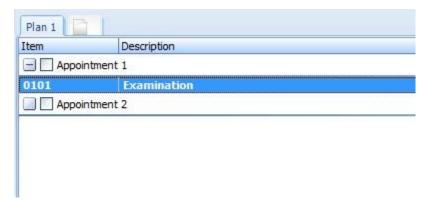
See the setup chapter of the manual to discover how to set quick codes up for each of your dentists.

After examining a patient it may be necessary to add additional visit(s) to the treatment form, if the proposed course of treatment can't be completed on the day of the examination.

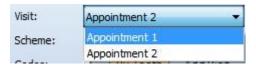
To add an additional visit, click the Add Visit button.



There will now be an extra visit (appointment) on your treatment form (example below). To add subsequent appointments, repeat this process.



To select the appointment you wish to add a treatment item to select the desired appointment from the dropdown button next **Visit**.

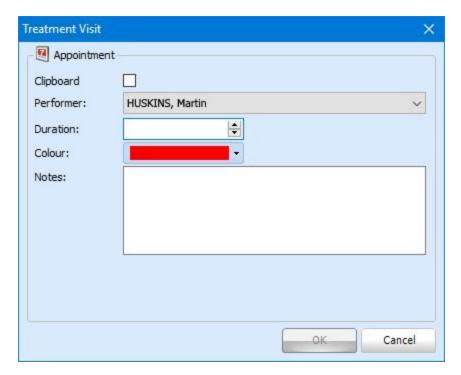


Select the treatment item you wish to add it will then appear under the appropriate appointment.

You can also drag and drop treatment items from one appointment to another. Hold the left button on your mouse down, hover over the appointment you wish to add the treatment item to, then release. This same method can be used for changing the order of appointments.

If you need to book a patient an additional appointment, you can let the reception know this from surgery.

Double click on the appointment. The following window appears.



To add the appointment to the treatment clipboard tick the checkbox named **Clipboard**. You can add the duration required, assign a colour to the appointment and add any notes if required.

Once you click the **OK** button, the appointment will now be on the treatment clipboard so reception can drag and drop the appointment to the desired time slot.

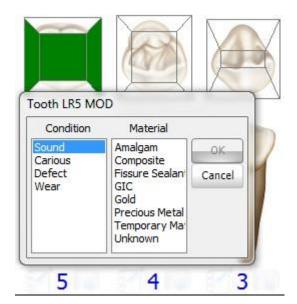
After creating a new treatment form (see creating a new form section of the manual) it will be necessary to add various treatment items. You have a choice of how you add these items. They can be added by tooth or by code.

To add treatment items by tooth, click on **By Tooth** on the screen shown below.

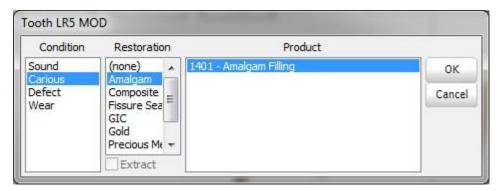


When you are in **By Tooth** mode you will notice on the chart there is a grid present over each tooth (whilst in anatomical mode), this is so you can select the necessary surface(s) of the tooth.

To add a treatment item to a tooth, click on the necessary surface(s) from the grid (example below).



Once you have selected a surface they appear green. To deselect a surface click on the surface again, the green coloured surface will revert back to clear. From the window that appears once one or more surface(s) are checked, you can select the condition and material. To select a condition, material / restoration and product click on the option you wish to select, the option will be highlighted in blue once selected.

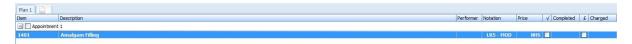


In this example the condition is Carious, we are going to use Amalgam for restoration, and from the product list we are going to select Amalgam Filling. Click **OK** to add the treatment item. You will see this is now present on the chart.



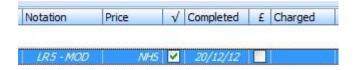


You will now see the treatment item at the bottom of the screen (example below).



Also note that down the left hand side of the screen the activity grid has been updated (only applicable to NHS courses of treatment in England and Wales).

Once a treatment item has been completed it is necessary to mark this on the treatment form.



Once you tick the **Completed** checkbox it populates the completed column with the date that marked the treatment item as completed. This then updates the activity box on the left hand side.

The next step is to charge the patient for the treatment item. To do this, tick the box under the **charged** heading.



Now the item has been charged, there is a date present in the **charged** column. As for proposed and completed the activity grid will now be updated.

To update the patients account you have two options once you have ticked the charged box. You can click the **Checkout** button if you wish to remain in the treatment form. Alternatively click the **Close** button. These buttons are found towards the top left of your screen (see below).



Once you have clicked either of these buttons you will notice that the patient's account balance will update (example below).



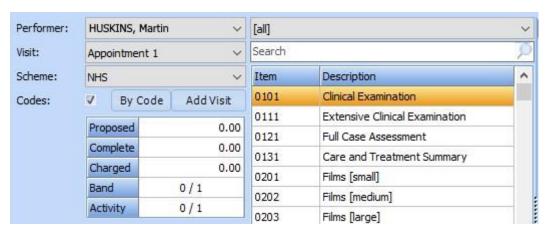
To see how to put through patient payments, refer to the Patients Accounts section of the manual.

The second way to add treatment items to a form is by code.

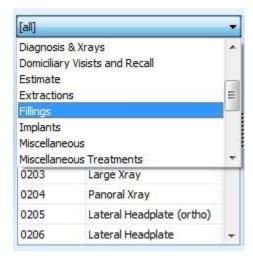
To activate this mode click on the **By Code** button towards the bottom left hand corner of the screen once you have opened a treatment form (see creating a new form section of the manual).



You will see the list of codes towards the bottom left of the screen.



By default all codes appropriate to the current mode will be listed. If you only want to view codes for a specific category you can choose from the dropdown.



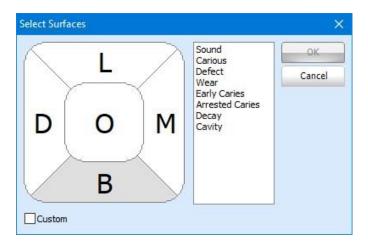
The next feature is the search filter. This is located under the category selection and can be used with it. Start typing the item or description name and the results will adapt to your search.



To add a treatment item such as an examination to the form double click on the desired item from the list. Tooth specific items such as fillings require the selection of a tooth, should you double click on one of these items the following warning will be presented.



Click **OK** and select the tooth from the chart. After clicking on the tooth, the following window appears (depending on which treatment item was selected).



Select the surface(s) required by clicking on it. Once selected, the tooth surface(s) will turn green.

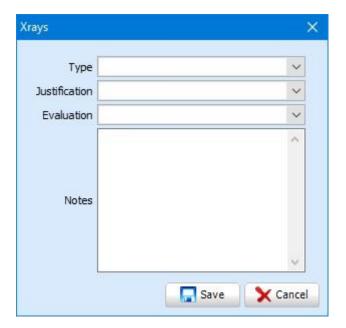
Click **OK** to confirm. This will now be added to the chart (example below).



Like the **By Tooth** section, once the treatment item has been completed and charged tick the check boxes next to the treatment item.



**Tip:** If you have any treatment completion screens setup for particular treatment items they will be presented when you tick the Completed Checkbox. See the 'Setup' section of the manual to see how to configure such screens.



Once you have **Completed** and **Charged** the treatment items, click either **Checkout** or **Close** at the top left of your screen to update the patient's account.

Assisting a practitioner obtain informed consent is part of any modern dental software, one way SFD v6 assists in this is to allow multiple proposed treatment options. You have the ability to do this within any treatment form, so you can see the alternative treatment plans side by side.

In the example we are going to initially open a standard NHS form (refer to creating a new treatment form section of the manual).

Now add the treatment items to the form (example below).



To add a second plan, click on the tab highlighted below within the red square.



You will be presented with the following window.



Click Yes, and you will see that the second plan has been added.



Click on plan 2. For this example we are going to demonstrate mixed forms, select private from the scheme dropdown menu on the left-hand side.





You can now add the same treatment items as Plan 1, and these will be added with the fees associated with the scheme selected (you will have to ensure the treatment items are activated for us in the particular scheme, see **Item Setup** section of the manual for more information).

You can rename the plans by right clicking on the tab you wish to change. After right clicking the following window appears.



Click **OK** to confirm. Our example of custom named plans is shown below.



To add any additional treatment options to the form, repeat the process above.

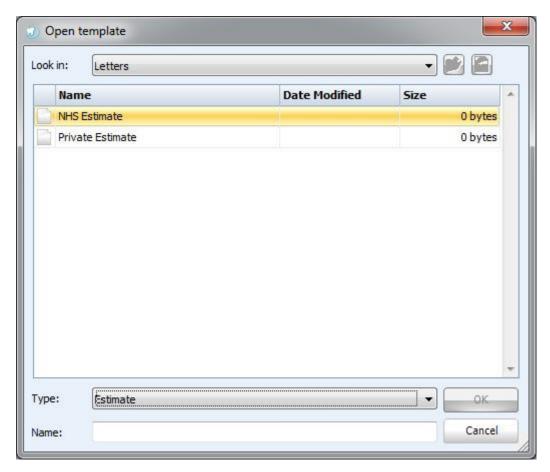
From the treatment form you have the ability to create **Estimates** (printed treatment plans), these are helpful as they give your patient a good idea of what treatment they require, the associated costs and add to your evidence of informed consent by documenting any treatment options you have suggested for the patient.

Once you have added treatment items to a form, click on the **Estimate** button towards the top of the screen.



After clicking **Estimate**, you are presented with the following screen.

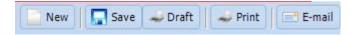




Dependant on your setup you may have an estimate template for each scheme you offer at your dental practice, these templates are fully customisable and the dental software supports a virtually unlimited number of templates, allowing you to create as many as you require. To open a template you can highlight the document by left clicking on it then click the **OK** button to open or double click on the document title.

Once you have clicked the **OK** button, your estimate will be generated with all the treatment items present on the treatment form.

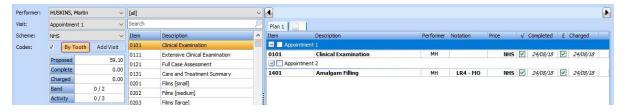
Once you have generated your treatment form you can do a number of things. You have the ability to save the estimate into the patient's correspondence (featured later in this chapter). Alternatively you can print or email the document. All this can be done from the top left of the screen.



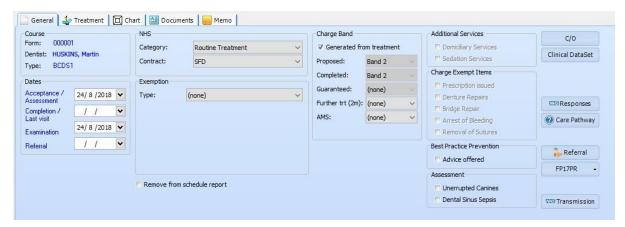
**Note:** You can also add digital patient signatures to the estimate. To do this you need a Wireless Signature Pad (WSP). Please contact Sales on **0845 643 2828** to find out more about this fantastic feature.

After the completion of an NHS treatment form it is important to transmit the form to the BSA. Once you have completed and charged treatment items, your treatment form may look similar to the example below.





From this example we can see it is a band 3 course of treatment and therefore 12 UDA's to be claimed for. The tab to the left is to access the General page, once a course of treatment is completed it will look similar to the below.

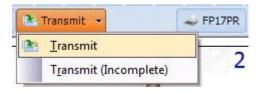


From the **General** page you can gather information such as the form number, dentist, and dates of acceptance / completion. You can also edit the contract and exemption type from this page if necessary. It is also possible to set a manual charge band however it is advisable to keep the **Generated from treatment** check box ticked as this automatically generates the correct charge bands associated with the treatment items present on the form.

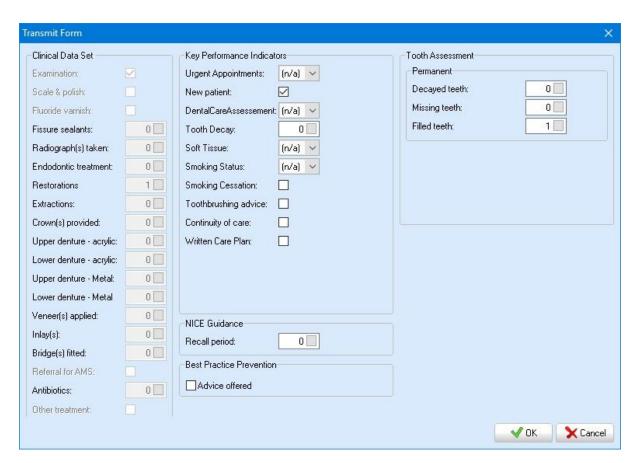
Once you are satisfied with all the information presented on the form, you are ready to transmit. To do this, click on the **Transmit** button towards the top of your screen.



After clicking the **Transmit** button you have two options, either **Transmit** or **Transmit** (**Incomplete**). **Transmit** (**Incomplete**), this is for cases where patients have attended for part of their course of treatment but haven't returned for the appointment(s) to complete the entire course, you should only claim as incomplete if treatment items have been started, refer to your NHS contract for guidance.

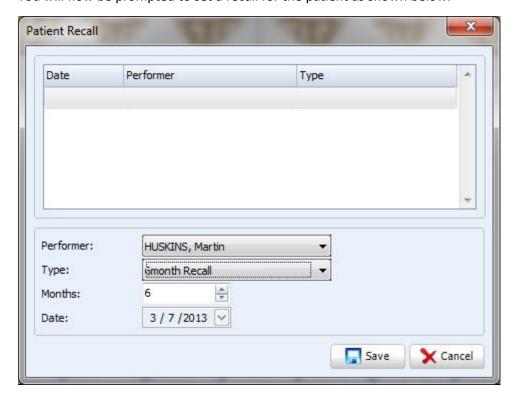


Once the appropriate selection has been made, you will be presented with the following window.



The treatment form will now be in the **Pending forms** section of the **Transmissions** screen (featured later in the manual).

You will now be prompted to set a recall for the patient as shown below.



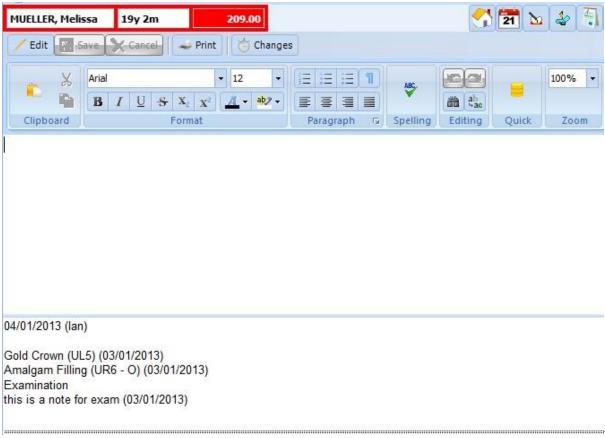


From this window you can select the performer, type of recall and how many months you wish to recall them in. Click the **Save** button to set the recall (learn how to send recalls later in the Reports section of the manual).

To enter the clinical notes section of the patient record, click on the Notes **icon** which is situated towards the top of the screen.



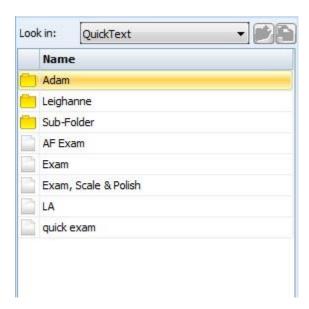
After clicking the **Notes** button you will be presented with the following screen.



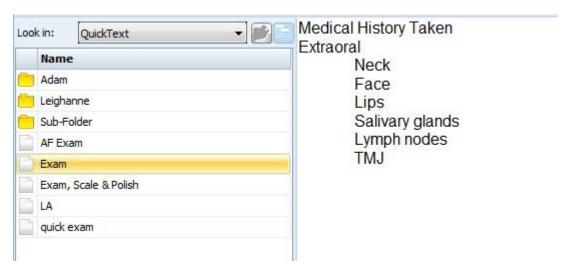
Notes can be entered in the box above. They can be formatted using the options above.

Templates can be found under the **Quick** button.

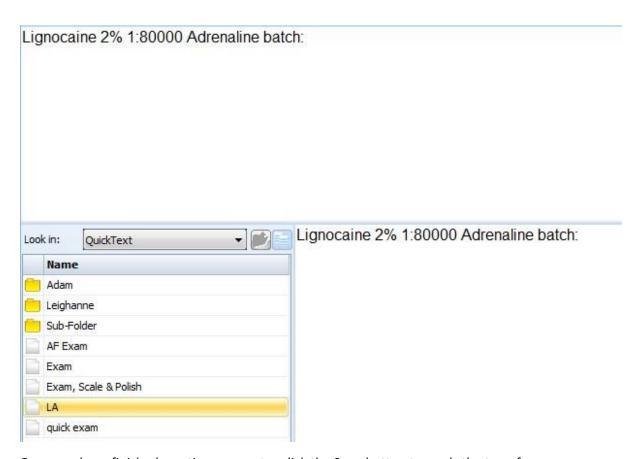




Notice that you can create subfolders to keep your quick texts categorised (refer to the **Quick Text Setup** section of the manual). To preview a quick text left click on the desired text from the panel on the far left of the screen.



To add one of the quick texts to your current notes double click on the note title from the menu.



Once you have finished creating your notes click the **Save** button towards the top of your screen, pressing the **quick** button will toggle on and off the quick text templates, allowing access to all the historical clinical notes for the patient.



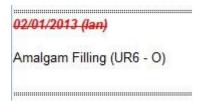
Note: Clicking on the cancel button will clear any notes written that have not been saved, this cannot be undone.

You have the ability to print your notes. To do so, click on the **Print** button.

To view historic notes scroll down the screen using the scroll bar towards the far right of the window.

It is vital for legal reasons that you are able to prove when your notes where written, altered and who entered them. For this reason we only allow editing of clinical notes on the day they were written, after which time you have to enter a new note.

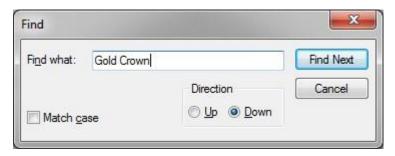
No clinical notes are ever truly deleted and changes can be accessed from the clinical notes section of the patient record. To view deleted and altered clinical notes click on the **Changes** button which is located next to the print button. Any notes that have been deleted will have the username and date in red with a strike through, as shown in the example below.



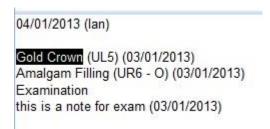
**Tip:** If you are searching for specific notes within a patient record that has a high volume of notes entered, you can use the Find Text feature. This is found in the top ribbon (icon shown below).



You will be presented with the following window.

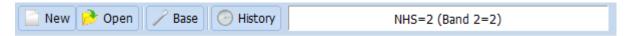


Enter your key word into the Find what text box, once you have done so click the Find next button which will become activated once you type into the box. The word you have searched for will now be highlighted (example below).

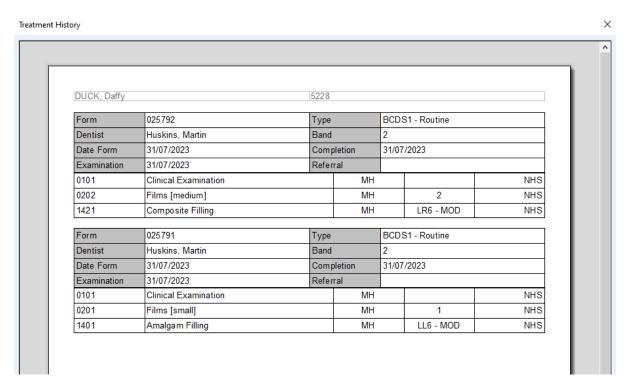


#### Treatment History

To view previous treatments, click 'History'.



A screen (seen below) will pop up, giving you essential information regarding each previous treatment received by the patient.

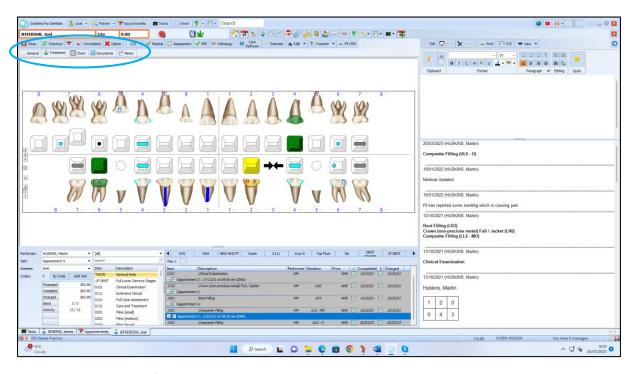


Note: You can print this document out by clicking print at the bottom left of the pop-up screen.



### **Base Charting**

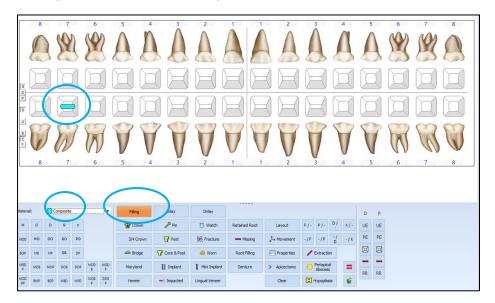
Once the user has created a course of treatment. The treatment screen will be visible in SFD.



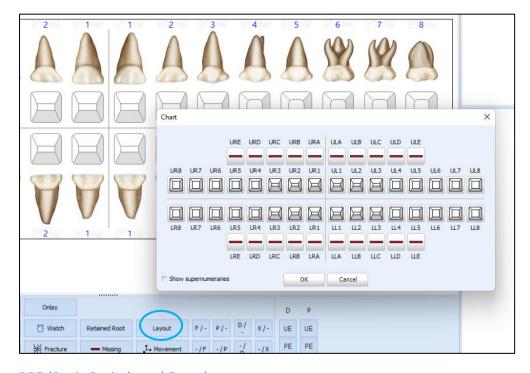
To create a **base chart** for a new patient, click the chart tab next to treatment.



**Quick select** options are available at the bottom. **Select an option** from the quick select button. Select your **material** from the drop down on the left. Then select the **tooth** to chart the information.



Select the **layout** button to add supernumeraries and mixed dentition.



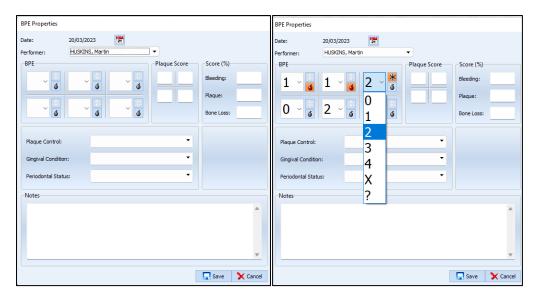
# BPE (Basic Periodontal Exam)

To record a basic periodontal exam, click the BPE button on the tool bar.



The **BPE properties** window should appear. Information can be recorded using the drop-down option or using the keyboard.





**Bleeding** will automatically appear for a **recording of 1** but it can be placed manually by clicking the **blood drop button**. **Furcation** can also be added by click the **star** above the blood drop.



If you record bone loss in your BPE, when you complete a periodontal exam, the classification will be automatically calculated for you.

NB: If bone loss is not entered your BPE window, the periodontal classification will be inaccurate.

Click **save** when complete.

### BEWE (Basic Erosive Wear Exam)

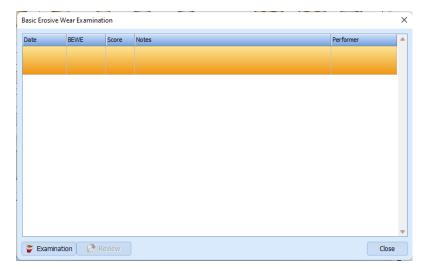
This examination allows you to record tooth wear in each sextant.

On the treatment section, click the bleeding tooth icon – 'BEWE'.



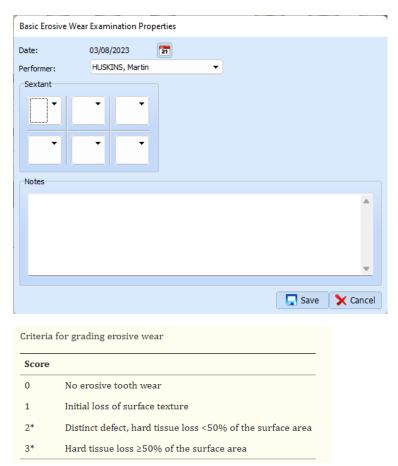


The following screen will be shown. On this screen, choose 'examination' at the bottom left of the window.



Once the following window is shown on screen, you can use either the drop downs to add in the value of each sextant or alternatively, you can use the number pad on your key board for quickness.

Once completed, you can add any notes regarding the examination and click save to complete the examination.



#### Perio Chart

To record a Periodontal exam, click **periodontal** button on the main menu.



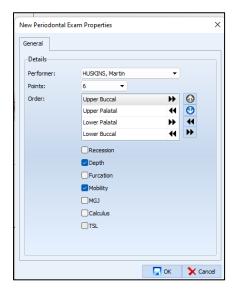




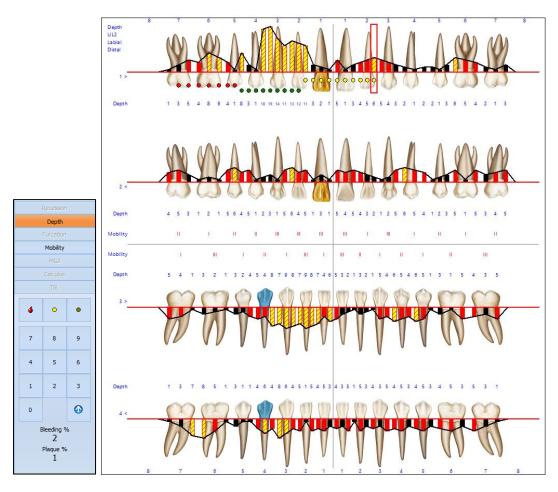
Click new on the tool bar.



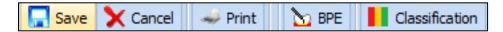
**Select** the required properties.



**Periodontal information** can be entered using the **number pad** on the left or by using the number keys on your keyboard. **Bleeding** (b), **Plaque**(p) and **suppuration**(s) can also be recorded in the same way.



Once completed click save.



Click the **Classification** button to complete the Periodontal check.

NB: You must have completed the bone loss information in the BPE for this to calculate correctly.



Click Ok when complete.

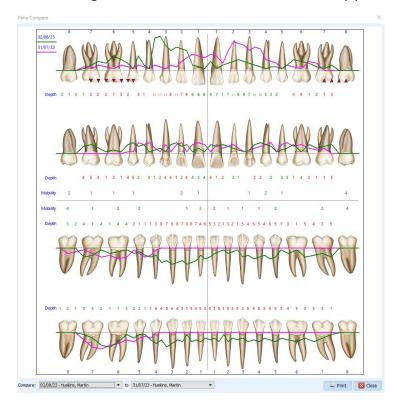
You can also compare periodontal charts if you have created more than one.



Click the 'compare' button.



The following window will be shown on screen whereby you can compare the different charts.

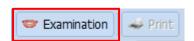


# Pathology

To complete a pathology examination, click the **lips icon**.



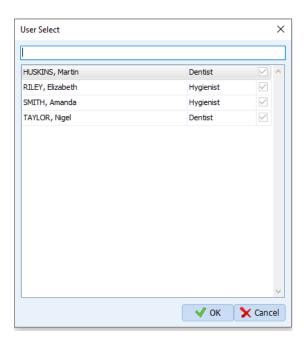
Click 'Examination'.



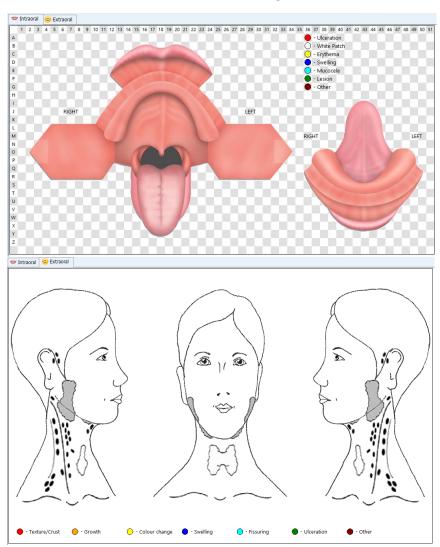
You can choose **no findings** if there are not any. However, if there are findings choose **full examination**.



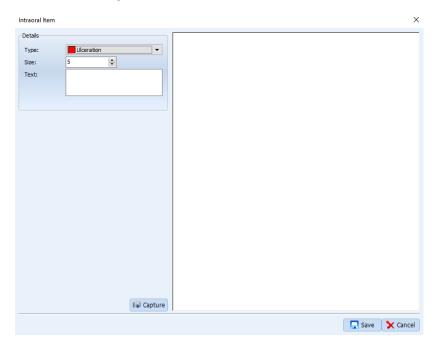
Select 'user' and OK.



Click an area of the Intraoral or Extraoral images.



To add an item, just click on the area of the image where there are findings. Once you have done this, the following screen will be shown.



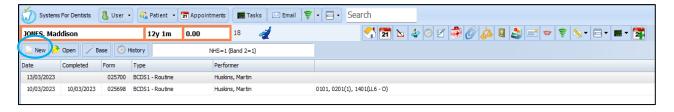
Choose the type, size (millimetres) and add any necessary text if needed. After that, click save.

### **Proposed Treatment**

To create a course of treatment for a patient you must first open the record. Once the record is open select the **treatment** button.

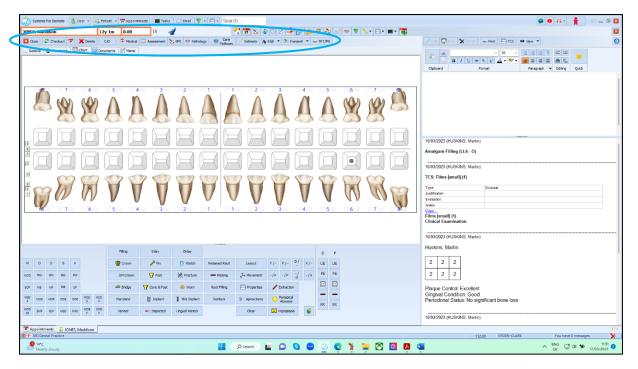


Select **new** from the main menu.



The **treatment screen** will appear and allow you to complete, medical questionnaires, periodontal, pathology, base charting and propose future treatments.

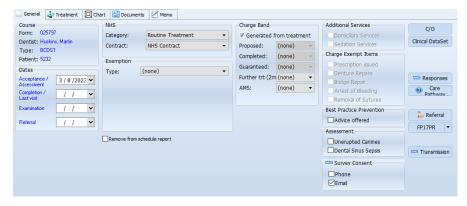




Using the different buttons on the main menu will allow you to access the different dental information screens.



The **general** tab gives you an overview of the patient's course of treatment as well as further details such as, dates, NHS category and contract, exemptions, charge band, additional services, charge exempt items, best practice prevention, assessment and if there is any survey consent.



The **chart** tab is where you can base chart as previously show on pg.37-39.

The **documents** tab shows you any documents that are relating to the course of treatment.

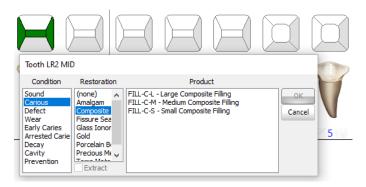


The **memo** tab is where you can add any notes for your reference.



The **treatment** tab allows you to create a proposed treatment plan. The treatment screen will appear that will allow you to add your **proposed treatment** and request an appointment.

Select the tooth or part of the tooth surface on the chart which requires proposed treatment and select the appropriate drop downs.



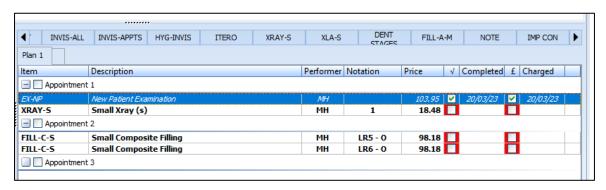
## NB: Sound should only be selected if you are completing base charting in the treatment tab.

Once the treatment is complete the user must record the treatment as complete, so items can be charged and closed.

Select the **treatment** tab and open the current course of treatment.



On the **treatment plan** select the items that have been completed. Click each item individually or check the box next to the appointment title to check all items.



To mark treatment as completed check each box in the price and complete columns.





Click **Complete** on the toolbar menu. (Private Patients only)

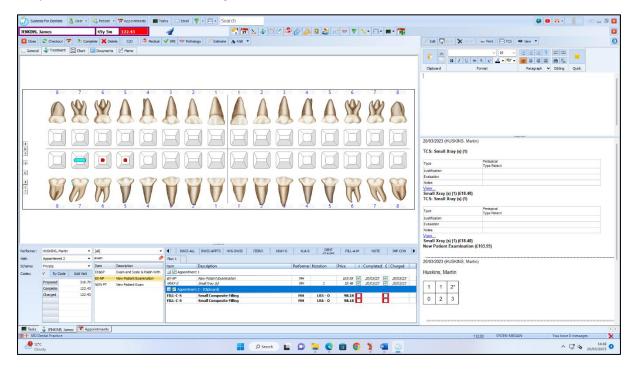


### **Making Notes**

Clinical notes can be accessed in SFD by clicking the **notes** button on the main menu.



They can also be accessed to the right of the **treatment screen**.



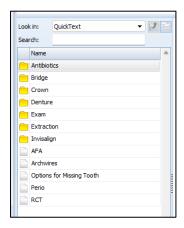
**Notes** can be entered manual by treating the **notes box** at the top and click save.



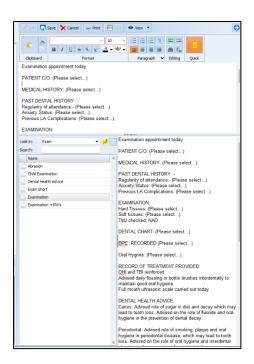
Notes can also be entered using **quick text** templates. Click **Quick** on the tool bar at the top of the note's windows



Select from the available quick text's templates.



Once the **quick text** has been selected it well appear in the edit window at the top. Click to edit the notes as required.



Click **save** when complete. Any clinical notes can be edited until 12am (Midnight). Notes cannot be changed after this point; a new note would need to be added.



### Checking out to confirm treatment and costs incurred for patient

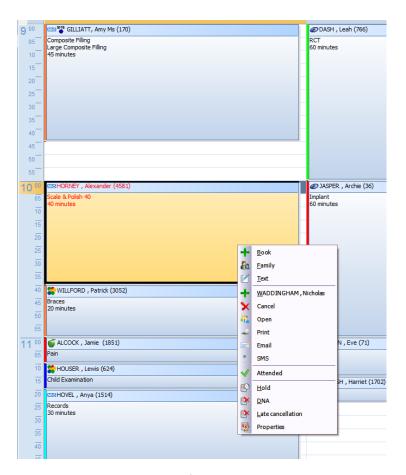
Once the appointments are completed, click the 'Checkout' button to save treatments and transfer the amount to be paid to reception.



Note: Following this, reception will take payment via the accounts icon.

### **Departing patients**

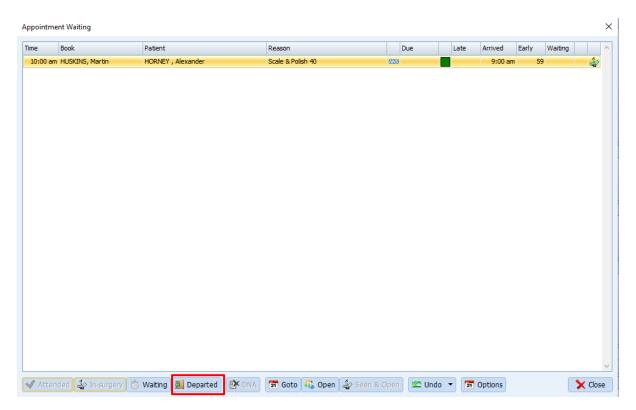
1. Right click on the appointment and click 'departed'.



2. Go to the top right of the screen and click the gingerbread man icon.



You will be met by the following screen. Choose the patient and click departed.



Note: On this screen you can also mark patients as attended and/or in surgery.

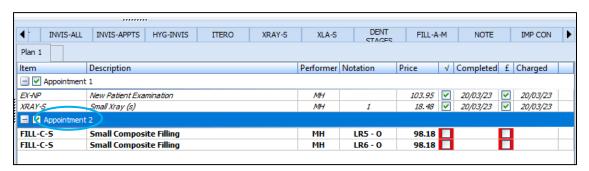
#### Booking future appointments

In SFD when a proposed **treatment plan** has been completed a future appointment for the proposed treatment needs to be requested.

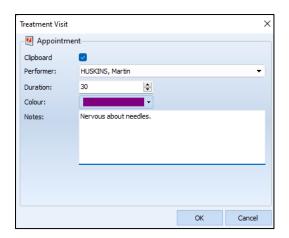
Select the Treatment tab.



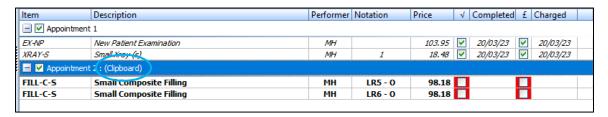
On the treatment plan double click on the appointment title.



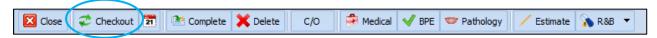
Select the **duration** of the appointment and add any specific notes.



Click **Ok** and the word clipboard will appear next to the title to indicate that the appointment has been requested on the treatment **clipboard**.



### Click Checkout to save and update.



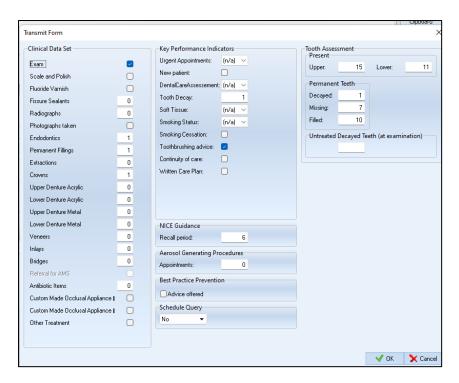
The appointment request will now be visible in the **treatment clipboard** in the appointment book.

## Transmitting and completing treatment

Once an NHS patient treatment has been complete, click **Transmit** on the toolbar. Select **Transmit** from the drop down.



Fill out the required details on the **NHS Treatment form**. Clinical data sets will have been calculated automatically based on your treatment completed.



Click Ok when complete.

Select the recall type and months. Click Save.

