

Data Collection Form 2: At time of mini screw / TAD removal or failure (with instructions)

British Orthodontic Society

National Audit of Mini Screws / Temporary Anchorage Devices (TADs)

Data Collection Form 2: At time of mini screw / TAD removal or failure

This form should only be completed when all TADs in the patient have failed or been removed.

Please complete the data collection form below for online submission or to download the form as a PDF document for postal submission to BOS [click here](#).

For instructions and help to complete the data collection form, please point cursor to ? and \* denotes mandatory field.

?TAD audit registration number *	<input type="text"/>
?Patient date of birth *	<input type="text"/> <input type="text"/> <input type="text"/>
?Number of mini screws / TADs inserted (Please complete two audit sheets if more than 4) *	<input type="text"/>
?Unique patient identifier i.e. hospital / practice number *	<input type="text"/>
?Is orthodontic treatment completed at date of form submission? *	<input type="radio"/> Yes <input type="radio"/> No
?Have mini screws / TADs provided desired anchorage? *	<input type="radio"/> Yes <input type="radio"/> No
TAD #1 Which jaw? *	<input type="radio"/> Maxilla <input type="radio"/> Mandible
Location *	<input type="radio"/> Lingual <input type="radio"/> Labial
?Adjacent teeth (FDI notation) *	<input type="text"/>
?Removal or failure? *	<input type="radio"/> Removal <input type="radio"/> Failure
Date of removal / failure *	<input type="text"/> <input type="text"/> <input type="text"/>
?Reason for failure	<input type="radio"/> Infection <input type="radio"/> Gingival inflammation <input type="radio"/> Excess mobility
?Any adverse effects recorded? *	<input type="radio"/> Gingival inflammation <input type="radio"/> Excess mobility <input type="radio"/> Damage to tooth root <input type="radio"/> No
?Screw replaced following loss or removal? *	<input type="radio"/> Yes <input type="radio"/> No
TAD #2 Which jaw?	<input type="radio"/> Maxilla <input type="radio"/> Mandible
Location	<input type="radio"/> Lingual <input type="radio"/> Labial
Adjacent teeth (FDI notation)	<input type="text"/>
Removal or failure?	<input type="radio"/> Removal <input type="radio"/> Failure
Date of removal	<input type="text"/> <input type="text"/> <input type="text"/>
Reason for failure	<input type="radio"/> Infection <input type="radio"/> Gingial inflammation <input type="radio"/> Excess mobility
Any adverse effects recorded?	<input type="radio"/> Infection <input type="radio"/> Gingival inflammation <input type="radio"/> Excess mobility <input type="radio"/> Damage to tooth root <input type="radio"/> No
Screw replaced following loss or removal?	<input type="radio"/> Yes <input type="radio"/> No
TAD #3 Which jaw?	<input type="radio"/> Maxilla <input type="radio"/> Mandible
Location	<input type="radio"/> Lingual <input type="radio"/> Labial

Adjacent teeth (FDI notation)

Removal or failure?

Date of removal / failure

Reason for failure

Any adverse effects recorded?

Screw replaced following loss or removal?

TAD #4

Which jaw?

Location

Adjacent teeth (FDI notation)

Removal or failure?

Date of removal / failure

Reason for failure

Any adverse effects recorded?

Screw replaced following loss or removal?

?Additional comments

Email address \*

Removal

Failure

Infection

Gingival inflammation

Excess mobility

Infection

Gingival inflammation

Excess mobility

Damage to tooth root

No

Yes

No

Maxilla

Mandible

Lingual

Labial

Removal

Failure

Infection

Gingival inflammation

Excess mobility

Infection

Gingival inflammation

Excess mobility

Damage to tooth root

No

Yes

No

Submit