# Ninisina Intelligence

## PHI-safe Alternate Bundles — Gated Pack Add-On

One alternate “Input → Output” bundle per specialty. Each includes: SOAP + charting support, patient instructions, and a referral/coordination letter. Fictional and de-identified.

Designed to be readable in ~30 seconds per bundle.

# Contents

# Oral Medicine / Orofacial Pain (OFP)

Alternate bundle (PHI-safe template).

## Follow-Up (TMD Improvement + Next Steps)

***1) De-identified capture***

```
Follow-up ~6 weeks. Pain improved from 6/10 to 3/10 with soft diet/heat. Still wakes with clenching. OTC nightguard helps. MIO improved to ~38 mm unassisted. No new red-flag symptoms.
```

***2) Generated SOAP + charting support***

| | |
|---|---|
| **S** | Follow-up: pain improved (now ~3/10). Persistent morning clenching; OTC nightguard helps. No new concerning symptoms. |
| **O** | MIO ~38 mm unassisted; tenderness decreased; joint sounds intermittent by report. |
| **A** | Improving TMD/myofascial pain; ongoing parafunction contributing. |
| **P** | Reinforce habit reversal; consider custom stabilization splint + PT; continue self-care; follow-up 6–8 weeks. |

***3) Patient instructions***

• Continue heat + gentle stretching as instructed.

• Daytime: ‘lips together, teeth apart’ reminders; avoid gum/chewy foods during flares.

• Nightguard: wear as directed; stop and call if pain increases.

• Call urgently for new swelling, fever, numbness/weakness, vision changes, or trouble swallowing/breathing.

***4) Referral / coordination letter (to: Referring provider (GDP/PCP/Neurology as applicable))***

```
Subject: OFP Follow-Up Update — TMD Improvement

Dear Colleague,
This is a follow-up update after conservative TMD care. The patient reports improvement in jaw/temple pain (now ~3/10 from ~6/10). Morning clenching persists; an OTC nightguard provides partial relief. No new red-flag symptoms reported.

Exam today: maximal opening improved (~38 mm unassisted) with decreased masticatory muscle tenderness compared to initial evaluation.

Assessment: improving myofascial/TMJ-related pain with persistent parafunction as a contributor.
Plan: continue self-care; reinforce habit reversal; consider custom stabilization appliance and/or physical therapy. Follow-up planned in 6–8 weeks.

Sincerely,
[Clinician Name, Credentials]
Ninisina Sample Clinic (PHI-safe example)
```

# Endodontics

Alternate bundle (PHI-safe template).

## Retreatment Consult (Suspected Missed Anatomy)

### *1) De-identified capture*

```
Consult for persistent bite tenderness on #3 years after prior RCT. Percussion mild+.
Palpation negative. Probing WNL. PA suggests periapical radiolucency and possible
untreated canal (MB2). Discussed retreat vs apico vs extraction; patient elects
nonsurgical retreat.
```

### *2) Generated SOAP + charting support*

| | |
|---|---|
| **S** | Persistent bite tenderness on previously treated #3; intermittent discomfort. |
| **O** | #3: percussion mild+; palpation –; probing WNL; PA suggests PARL + possible missed canal (MB2). |
| **A** | Previously treated tooth with suspected persistent apical periodontitis; possible missed anatomy. |
| **P** | Reviewed options (retreat vs surgery vs extraction). Patient elects nonsurgical retreat; review risks; schedule retreat; interim pain guidance. |

### *3) Patient instructions*

• Avoid very hard chewing on the tooth until treatment is completed.

• Use OTC pain relievers as directed (follow label).

• Call if swelling, fever, drainage, or rapid worsening pain occurs.

• Keep the retreatment appointment; definitive restoration may be recommended after completion.

### *4) Referral / coordination letter (to: Referring GDP)*

```
Subject: Endodontic Consultation — Tooth #3 (Retreatment Recommended)

Dear Doctor,
Thank you for the referral. Evaluation of tooth #3 (previously treated) shows mild
percussion tenderness with radiographic findings suggestive of persistent apical
periodontitis and possible missed canal anatomy (e.g., MB2). Probing was within normal
limits and palpation was negative.

Assessment: previously treated tooth with suspected persistent apical disease.
Plan: discussed retreatment vs apical surgery vs extraction. Patient elected nonsurgical
retreatment; we will proceed as scheduled. Following completion, definitive coronal
restoration is recommended as indicated.

Sincerely,
[Endodontist Name, DDS/MS]
Ninisina Sample Clinic (PHI-safe example)
```

# Prosthodontics

Alternate bundle (PHI-safe template).

## Full-Arch Rehabilitation Planning (Phased Care)

***1) De-identified capture***

```
Consult for severe tooth wear with esthetic and functional concerns. Discussed phased
approach: diagnostic records (photos/scans/CR), provisionalization to test VDO/occlusion,
then definitive restorations. Reviewed time, maintenance, and risks
(sensitivity/fracture).
```

***2) Generated SOAP + charting support***

| | |
|---|---|
| **S** | Concerns: wear, function, esthetics; desires durable long-term solution. |
| **O** | Generalized wear; occlusal evaluation needed; diagnostic records planned. |
| **A** | Severe tooth wear with functional/esthetic impact; candidate for phased full-arch rehab. |
| **P** | Phase 1 diagnostics; Phase 2 provisionals to test VDO/occlusion; Phase 3 definitive restorations; discuss maintenance and risks. |

***3) Patient instructions***

• Next visit will focus on records (photos/scans/bite records) to confirm the plan.

• Report jaw soreness, headaches, or bite discomfort during provisional testing—this guides adjustments.

• Maintain meticulous home care; keep hygiene/maintenance visits on schedule.

• Call if a provisional cracks/loosens or if you develop escalating pain/swelling.

***4) Referral / coordination letter (to: Multidisciplinary team (e.g., perio/OMS as needed))***

```
Subject: Full-Arch Rehabilitation Planning — Coordination (Diagnostics Pending)

Dear Colleague,
I evaluated a patient with generalized tooth wear and functional/esthetic concerns. We
discussed a phased full-arch rehabilitation approach: (1) diagnostic records
(photos/scans/CR) to define occlusion and esthetic goals, (2) provisionalization to test
VDO/occlusion, then (3) definitive restorations.

If multidisciplinary sequencing is needed (e.g., periodontal stabilization, surgical
considerations), I will share finalized records once complete so we can align timing and
responsibilities.

Sincerely,
[Prosthodontist Name, DDS/MS]
Ninisina Sample Clinic (PHI-safe example)
```

# Pediatric Dentistry

Alternate bundle (PHI-safe template).

## Sedation Day (Moderate Sedation) Template

***1) De-identified capture***

```
Sedation visit for restorative care. Pre-op checklist completed; NPO confirmed; baseline
vitals WNL. Treatment completed as planned. Recovery uneventful; discharge criteria met.
Written instructions reviewed with caregiver.
```

***2) Generated SOAP + charting support***

| | |
|---|---|
| **S** | Sedation visit for dental treatment; caregiver present; pre-op review completed. |
| **O** | Pre-op: NPO confirmed; baseline vitals WNL. Intra-op: treatment completed. Recovery: stable; discharge criteria met. |
| **A** | Dental disease treated under moderate sedation; no complications noted. |
| **P** | Discharge instructions provided; pain plan per protocol; follow-up scheduled. |

***3) Patient instructions***

• Adult supervision for the rest of the day; quiet activities only.

• Start with clear liquids → soft foods as tolerated; avoid heavy meals if nauseated.

• Use medications only as directed; encourage hydration and rest (drowsiness expected).

• Call urgently for breathing difficulty, persistent vomiting, uncontrolled bleeding, fever, worsening swelling, or severe pain not improving.

***4) Referral / coordination letter (to: Referring provider (GDP/pediatrician as appropriate))***

```
Subject: Pediatric Dental Treatment Under Moderate Sedation — Summary

Dear Colleague,
The child received planned dental treatment under moderate sedation. Pre-op requirements
were confirmed (including NPO status) and baseline vitals were within normal limits.
Treatment was completed as planned, recovery was uneventful, and discharge criteria were
met.

Caregiver received written/verbal post-sedation and dental aftercare instructions with
return precautions. Follow-up is scheduled per protocol.

Sincerely,
[Pediatric Dentist Name, DDS/MS]
Ninisina Sample Clinic (PHI-safe example)
```

# Orthodontics

Alternate bundle (PHI-safe template).

## Unscheduled Repair (Broken Bracket / Wire Poke)

***1) De-identified capture***

```
Unscheduled visit: bracket debonded upper left; wire irritating cheek. No trauma. Rebonded
bracket and trimmed wire; tissue mild erythema. Provided wax and care instructions. Keep
next scheduled visit.
```

***2) Generated SOAP + charting support***

| | |
|---|---|
| **S** | Reports loose bracket and wire irritation; no injury reported. |
| **O** | Debonded bracket UL; wire irritation to buccal mucosa; mild erythema. |
| **A** | Appliance issue — debonded bracket with soft-tissue irritation. |
| **P** | Rebonded bracket; adjusted wire; provided wax/instructions; dietary guidance; keep next scheduled visit. |

***3) Patient instructions***

• Avoid hard/sticky foods that can loosen brackets/wires.

• Use orthodontic wax for irritation; warm salt-water rinses as needed.

• Maintain brushing and interdental cleaning around appliances.

• Call if repeated poking, multiple loose brackets, significant pain, or swelling.

***4) Referral / coordination letter (to: Referring GDP (if shared care))***

```
Subject: Orthodontic Appliance Repair Visit — Brief Update

Dear Doctor,
The patient was seen for an unscheduled repair: an upper-left bracket had debonded and the
wire was causing cheek irritation. The bracket was rebonded and the wire adjusted/trimmed.
Soft tissue showed mild erythema only. The patient received wax and home-care/diet
instructions and will continue with the regular treatment schedule.

Sincerely,
[Orthodontist Name, DDS/MS]
Ninisina Sample Clinic (PHI-safe example)
```

# Periodontics

Alternate bundle (PHI-safe template).

## Re-Evaluation After SRP (Residual Sites)

***1) De-identified capture***

```
Re-eval ~6 weeks after SRP. Patient reports less bleeding. Most sites now 3–4 mm; isolated
5 mm sites persist with BOP. Discussed localized adjunct therapy and periodontal
maintenance interval (q3–4 months).
```

***2) Generated SOAP + charting support***

| | |
|---|---|
| **S** | Reports improved comfort and reduced bleeding after SRP. |
| **O** | General improvement; most sites 3–4 mm; isolated 5 mm sites with BOP persist (documented). |
| **A** | Periodontitis improving; residual localized inflammation at select sites. |
| **P** | Consider site-specific adjunct at persistent sites; reinforce home care; periodontal maintenance q3–4 months; recheck next maintenance. |

***3) Patient instructions***

• Continue daily home care (brushing + interdental cleaning) as instructed.

• Keep periodontal maintenance visits every 3–4 months to maintain stability.

• Call if new swelling, fever, increasing pain, or drainage occurs.

• If adjunct therapy is planned, follow site-specific instructions provided.

***4) Referral / coordination letter (to: Referring GDP)***

```
Subject: Periodontal Re-Evaluation After SRP — Response Summary

Dear Doctor,
This is an update following SRP. The patient reports reduced bleeding and improved
comfort. Clinical re-evaluation shows generalized improvement with most probing depths now
3–4 mm. A few isolated sites remain at ~5 mm with bleeding on probing (documented).

Assessment: periodontitis improving with residual localized inflammation.
Plan: reinforce home care; consider site-specific adjunct therapy at persistent sites;
continue periodontal maintenance every 3–4 months and reassess residual sites at the next
visit.

Sincerely,
[Periodontist Name, DDS/MS]
Ninisina Sample Clinic (PHI-safe example)
```

# Oral & Maxillofacial Surgery (OMS)

Alternate bundle (PHI-safe template).

## Implant Placement (Single Implant) Template

***1) De-identified capture***

```
Planned single-implant placement at healed edentulous site. Consent reviewed. Local
anesthesia. Osteotomy prepared; implant placed with good primary stability; healing
component placed; sutures placed. No complications. Post-op instructions reviewed.
Follow-up for post-op check; coordinate restorative timeline.
```

***2) Generated SOAP + charting support***

| | |
|---|---|
| **S** | Presents for planned implant placement; consent reviewed; questions answered. |

| | |
|---|---|
| **O** | Local anesthesia; osteotomy prepared; implant placed with primary stability; closure completed; tolerated well. |
| **A** | Edentulous site treated with implant placement. |
| **P** | Post-op instructions and meds per protocol; post-op check scheduled; coordinate restorative milestones after osseointegration. |

***3) Patient instructions***

• Do not disturb the site (avoid pulling lip/cheek to look).

• Soft diet for several days; avoid chewing directly on the surgical side as instructed.

• Take medications only as directed; use ice packs if recommended.

• Call urgently for persistent bleeding, increasing swelling, fever, worsening pain, or a loose healing component.

***4) Referral / coordination letter (to: Restorative dentist)***

```
Subject: Implant Placement Update — Restorative Coordination

Dear Doctor,
A single implant was placed at a healed edentulous site. Local anesthesia was used;
osteotomy prepared; implant placed with good primary stability and a healing component
placed; sutures and hemostasis achieved. No complications were noted.

Next steps: post-op check is scheduled. After appropriate osseointegration/healing, we can
coordinate the timing for scan/impression and definitive restoration. Please share your
preferred restorative workflow so we can align milestones.

Sincerely,
[Surgeon Name, DDS/MD]
Ninisina Sample Clinic (PHI-safe example)
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