



Errors in the preparation of certificates and prescriptions by students of dentistry

Marcio Antonio Rodrigues Araujo^a, José Ribamar Alves Arruda^b, Larize Karine Duarte Silva^b,
Rejane Cristine de Sousa Queiroz^a

Abstract

Objective: To assess the fulfillment of fit notes and prescriptions by final-year students of a DDS program at a university in São Luís, Maranhão, with an aim towards analyzing ethical and legal standards.

Methods: Three hundred fifty-one dental records were analyzed, which were obtained from patients for whom dental care was provided by final-year dental students. Data were obtained by collecting relevant information from fit notes and prescriptions using a specific form.

Results: From the total of patients' records evaluated, 33.6% were found to have prescriptions and fit notes included (100 prescriptions; 18 fit notes). The most common errors found in fit notes were: absence of patient's signature (88.89%); absence of dentist's stamp (33.33%); absence of dentist's signature (22.22%); and absence of a copy obtained through an interleaving carbon-paper sheet (22.22%). Moreover, the most common errors observed in prescriptions were: absence of patient's signature (88%); absence of patient's address (87%); absence of dentist's stamp (66%); and absence of a copy obtained through an interleaving carbon-paper sheet (36%).

Conclusion: Considering the failures observed, we highlight the importance of professors in providing support and coping with the improvement of fit notes and prescriptions. The goal is dental students to become aware of the fact that this activity is one of the steps towards a good dental practice, which includes from ethical to legal aspects, as well as respect for patients.

Key words: Prescriptions; Fit notes; Ethical and legal standards; Errors

^aFederal University of Maranhão, Maranhão, Brazil
^bCEUMA University, Maranhão, Brazil

Erros na elaboração de atestados e receitas por alunos de odontologia

Resumo

Objetivo: Analisar o preenchimento dos atestados e receitas de acordo com as normas éticas e legais dos acadêmicos do último ano do curso de Odontologia de uma universidade em São Luís, Maranhão.

Metodologia: Foram analisados 351 prontuários odontológicos correspondentes aos pacientes atendidos por alunos do último ano do curso de Odontologia. Foi utilizado um formulário para a coleta dos dados pertinentes aos itens a serem analisados nas receitas e atestados.

Resultados: Foram encontrados 100 receitas e 18 atestados em cerca de 33,6% dos prontuários analisados. Nos atestados, os erros mais encontrados foram: ausências da assinatura do paciente (88,89%), do carimbo do profissional (33,33%), da assinatura do profissional (22,22%) e da via carbonada (22,22%). Nas receitas, os erros mais encontrados foram: ausências da assinatura do paciente (88%), do endereço do paciente (87%), do carimbo do profissional (66%), e uso de via não carbonada (36%).

Conclusão: Diante das falhas observadas pode-se destacar a importância do professor em acompanhar e orientar a elaboração desses documentos para que o aluno possa se tornar consciente que essa atividade também está inserida no bom exercício da odontologia, e sobre os aspectos éticos e legais relacionados à prática da odontologia e ao respeito ao paciente.

Palavras-chave: Receitas; Atestados; Normas éticas e legais; Erros

Correspondence:

Marcio Antonio Rodrigues Araujo
mmantra@ig.com.br

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Introduction

The dentist has a role of great responsibility in society by taking care of the health of human beings. It is due to such a responsibility that there are ethical and legal standards surrounding the clinical practice, some of which leading to the development of fit notes and prescriptions, which become thus part of this context [1].

Drug prescription is a written order directed to both pharmacists and patients in order to define how a drug ought to be delivered to the patient and determining the conditions under which it should be utilized. It constitutes a legal document by which are responsible the prescriber (dentist) and the pharmacist, who dispenses the medication. Both health-care professionals are subject to sanitary control and surveillance legislation [2].

The fit note is a legal document issued by the dentist, which consists of a simple written statement regarding a dental-related event and its consequences. It aims to establish the veracity of a fact or existence of a particular state, occurrence or obligation. Its unique purpose is to determine a current or previous state of health and/or disease for licensing purposes, dispensing or justification of absence from work, among others [3].

Accordingly, Dentistry is a profession which relies on details, and the non-compliance of such details may lead the clinician to be at risk of causing harm to patients, resulting in possible legal implications [4]. Errors in clinical documentation reflect both the character and operating mode of health-care professionals. They also reinforces that the professional responsibility should lead clinicians to become more prudent in terms of preparation and filing of dental records. Thus, the correct preparation and filing of dental records by higher education institutions help to educate students about the importance of this activity. As a result, they can become organized professionals and aware of their ethical and legal obligations. Furthermore, the dental record is considered to be the best tool for obtainment of evidence necessary for defense in case of legal proceedings [5].

The responsibility for dental records should be initiated at the university, during the training process of dental students [6]. Patients treated in school clinics have the same rights and obligations of any other patient, similarly to professors or institutions. Therefore, all the rules of conduct and preparation of records should also be followed by the institution, whereas prescriptions and fit notes are expected to be issued only when required [7].

The prescription of medications is standardized by the Federal Laws No. 5,991 of 1973 and No. 9,787 of 1999, the Resolution No. 357 of 2001, and the Collegiate Board Resolution No. 44 of 2010. Yet, the competence of the dental surgeon for issuing fit notes is regulated by the Laws No. 5,081 of 1966 and 6,215 of 1975.

Therefore, this study aimed at assessing the fulfillment of prescriptions and fit notes by last-year dental students towards verifying whether they are in accordance with ethical and legal standards, contributing thus to the professional

development of future dentists who should be aware of their professional obligations.

Methods

The study design was cross-sectional, retrospective, and descriptive. Secondary data was collected from dental records and were analyzed using quantitative and qualitative approaches.

In order to carry out this work, all medical records of patients seen during the first semester of 2012 in the disciplines of Clinical Integrated Internship I and Clinical Integrated Internship II were consulted, which are both components of the DDS final-year program at University CEUMA, São Luís, Maranhão. A total of 351 dental records were included; however, only those records which contained copies of fit notes and/or prescriptions were utilized in the survey.

For the evaluation of fit notes, the presence or absence of several items required for their composition was taken into account. The following items were considered: patient's identification, motivation (International Classification of Diseases – ICD), date, professor's signature and stamp, patient or its guardian's signature, and copies obtained using interleaving carbon-paper sheets. For the analysis of prescriptions, it was observed the presence or absence of the following items: copies obtained using interleaving carbon-paper sheets, legible handwriting, patient's identification and address, information regarding the administration of medication, use of abbreviations, date, professor's signature and stamp, and patient's signature. All information was collected in a specific form developed for this study and applied by a single investigator.

Data were collected and tabulated using Excel (Microsoft Office 2011). They were then analyzed by descriptive statistics using Stata 10.0, and illustrated in tables and graphs.

As it comes to secondary data, whose data collection was performed when clinical records were obtained from patients seen at the Dental School Clinic at University CEUMA, the Informed Consent Form (ICF) had been previously signed by the patients in order to the data to be used for purposes of treatment and research. Nevertheless, ICF dispensing was requested to the Research Ethics Committee as recommended by Resolution 196/96 of the National Health Council. The present study was submitted to the Research Ethics Committee of University CEUMA.

Results

Three hundred fifty-one dental records were included, 100 of which were found to be prescriptions and were 18 fit notes, totaling 118 documents (33.6%), which presented with errors in least one item analyzed.

Chart 1 shows the results for the analysis of fit notes. It was found that 22.22% did not contain a copy obtained through an interleaved carbon sheet, 22.22% did not have a

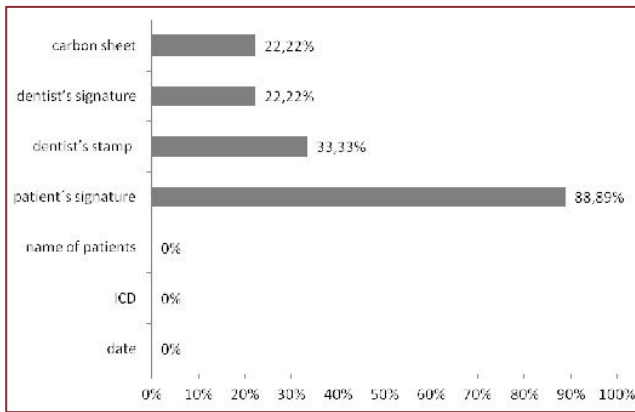


Chart 1. Distribution of errors identified in the fit notes analyzed

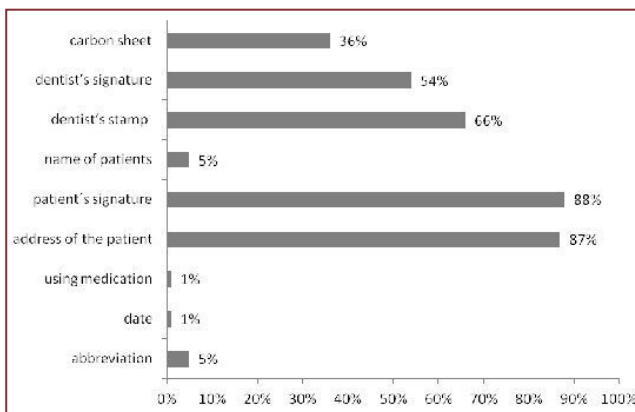


Chart 2. Distribution of errors identified in the prescriptions analyzed

Marcio A. R. Araujo
Cirurgião Dentista – CRO 1145 - Clínico Geral

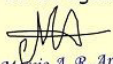
Para: Sra. Isabella Azevedo
Endereço: Rua X, nº Y, aptº Z.

Uso Interno:

1) Amoxicilina (500 mg) - comprimidos - 1 caixa

Tomar um comprimido, via oral, a cada 8 horas, durante 10 dias.

São Luís, 30 de agosto de 2015


 Marcio A. R. Araujo
 Cirurgião Dentista – CRO 1145 -
 Clínico Geral

Av. Colares Moreira, 100, sala 316 – Ed. São Luís Multiempresarial
Tel. XXXX XXXX E-mail: xxxxxxxx@ig.com.br

Figure 1. Model of drug prescription

dentist's signature, a dentist's stamp was absent in 33.33%, and 88.89% did not have a patient's signature. On the other hand, no error was observed in terms of patients' full names, date or ICD.

According to Chart 2, all of the ten items analyzed in prescriptions presented with some type of error, 36% of which did not contain a copy obtained using an interleaved carbon sheet, 4% were not legible, 5% did not include a dentist's signature, and 5% did not include the patient's name. In 66% of prescriptions, the dentist's stamp was absent, and the patient's signature was not observed in 88% of them. The patient's address was not found in 87% of prescriptions, and 15% contained abbreviations in this document. Only 1% did not include both date and information regarding the administration of medication.

Discussion

The exercise of professional activities which are exclusive of the dentist is allowed only with the observance of the provisions of the Laws No. 4,324 of 1964 and No. 5,081 of 1966, the Decree No. 68,704 of 1971, and the Resolution CFO-185 of 1993. According to these standards, the dentist is able to issue fit notes attesting morbid states as well as other types of states, which includes those ones for justification of absence from work, provided that justification has support in the field of his professional activity [8-11].

Dental factors which lead to absences from work have been increasingly targeted by the public and private sectors, leading researchers to investigate the major factors involved with this issue [12]. Nevertheless, in addition to aspects such as gender, age groups and the major dental causes of absenteeism already known, the methods of justification of such absences are also considered to be a relevant issue.

It was observed that as older as patients' age group become, longer is the absence from work due to dental causes [13]. This conclusion was reported considering the analysis of dental fit notes documented in a Brazilian public agency. On the other hand, the investigation did not take into account the possibility of documents filed to contain errors. In fact, data reported regarding this aspect remain scarce.

For purposes of legal proof, only documents that comply with the relevant legislation are to be accepted. Thus, dental fit notes must be written on letterhead or prescription paper, containing patient's identification, dentist's identification and signature, professional registration number in the Regional Council of Dentistry, and stamp. It should also contain date and time of the procedure, ICD code, and the rest period or period of absence from work or other activities needed by the patient [14].

Therefore, ethical and legal standards should guide the preparation of prescriptions, fit notes, medical records, among other types of documents considered as dental records. Failures in documentation of such records may lead to ethical and legal conflicts [15].

The total number of documents analyzed in this study (33.6%) is similar to another study carried out with dentists,

which found that only about 30% of the dental records investigated contained copies of fit notes and prescriptions [16]. Yet, it was found to be lower than the results of another study with graduate students, which observed that 50% of the total analyzed included proper records [17].

In this study, the error with highest incidence in fit notes was the lack of patient's signature (88%), a much higher percentage when compared to the found by Brito [16], which documented 13.5%. This may be associated with the fact that the students do not pay attention to the importance of having a copy of fit notes filed, with patient's consent and a state affirming that the fit note was delivered. However, in order to meet administrative, clinical and legal criteria, the documentation must be complete and include patient's identification. Still, as recommended by the Code of Dental Ethics, fit notes must be handwritten or typed and always signed by the patient [18].

The absence of dentist's stamp (33.33%) and dentist's signature (22.22%) were then observed. According to Article 18 of the Code of Dental Ethics approved by the Resolution 118 of 2012, it is considered an ethical infraction to prescribe or issue fit notes without proper identification, including the registration number in the Regional Council of Dentistry at the proper jurisdiction [19]. The Article 11, Resolution No. 87 of 2009 of the Brazilian Federal Council of Dentistry states that official expert dentists must only accept fit notes for evaluation of absence from work/activities when issued by licensed dentists and registered in a Regional Council of Dentistry. They should state unequivocally and legibly professional's full name with no abbreviation, registration number in the jurisdiction council, and signature [20]. To our knowledge, the absence of dentist's signature and stamp affects the validity and acceptance of the document for its purposes (i.e. absence from work or school, among others). In this case, patients might have their right of justification damaged.

According to Barros [21], fit notes are expected to be issued in a specific type of paper, printed paper in agreement with legal standards, or in a blank prescription paper, containing an interleaving carbon-paper sheet towards keeping a copy in the patient's records after delivering the original document to the patient. Hence, if the clinic already has a form for this purpose, it should be filled out, the professor's signature should be included, and an interleaved carbon sheet used in order to obtain a copy that will remain in the patient's records [22]. Our results demonstrated that 22.22% of records did not have a copy of the fit note obtained through an interleaving carbon-paper sheet. This may represent a serious failure, considering the fact that the document filed might not necessarily match to the one issued to the patient. The preparation of dental fit notes in duplicate can provide the dentist with a legal guard of the burden of proof [4].

Failures in terms of the inclusion of patient's signature and interleaving carbon-paper sheets were also identified in a study, which found that 53.9% of the dentists did not issue fit notes in duplicate or collect the patients' signatures.

Curiously, although some authors report the inclusion of stamps on dental fit notes to be mandatory [6,7,14,21], this aspect does not appear clearly in the legislation which regulates dental fit notes, described by the Laws No. 5,081 of 1966 and No. 6215 of 1975, the Code of Dental Ethics approved by the Resolution No. 118 of 2012 of the Brazilian Federal Council of Dentistry, and the Resolution No. 87 of 2009 of the Brazilian Federal Council of Dentistry [9,19,20,24]. Hence, the need of using the stamp is likely to be established by practice rather than by law.

Furthermore, all fit notes were found to include the ICD code; however, according to the guidelines of Minas Gerais Regional Council of Dentistry [3], ICD diagnosis should only be included when requested by patients. Still, it is suggested to collect the patients' signature when the ICD code is included, demonstrating thus its agreement with this procedure.

Another aspect in relation to the analyzed fit notes is that, when evaluating the printed-paper used in fit notes, it was observed that it contained no specification of its aims, but only the expression "for appropriate purposes". However, one must specify the objective of the fit note (i.e. work, school, sports, military), avoiding the term "appropriate purposes" [25].

A study with oral health coordinators in the public service revealed that 33.33% and 50% of these professionals recognize fit notes and prescriptions, respectively, to be essential items in the composition of dental records. Yet, 88.89% of dental coordinators were found to know the correct procedure to issue copied documentation (e.g. additional tests, prescriptions, fit notes, among others) and the need of patient's signature confirming that the documentation was properly delivered [26].

Regarding the prescriptions, in accordance with Article 35, Chapter VI of the Federal Law 5,991 of 1973, only the prescriptions written in ink, in full, and legibly are to be dispensed. The nomenclature, weight system and official measures should also be taken into account. Still, it must contain the name and home address of the patient, date, dentist's signature, home/office address, and registration number in the professional council, as well as information regarding the administration of the medication [27]. The Article 21 of Resolution 357 of 2001 adds that the prescription should be clearly signed and accompanied by a stamp, allowing the identification of the dentist if necessary [28]. This same resolution also states that prescriptions unreadable, containing codes (i.e. acronyms, numbers, etc.), or those which are likely to mislead or exchange the drug delivery should not be dispensed.

A high number of prescriptions analyzed in this study (87%) presented without patient's address or name (5%), which is considered to be a failure with judicial value, similarly to failures in the filing of medical records. Since it is a personal document, it is addressed exclusively to the patient; however, in the case mentioned, the patient could not be identified, and there is no proof confirming that patient was provided with the original prescription. Furthermore, the

prescription is a personal document and directed specifically to that patient; thus, it must contain its name and address, characterizing its personality [29].

Dental prescriptions and all documentation should be written with legible handwriting, providing information regarding the proper dosage towards limiting self-medication and working as legal a proof in cases of improper drug use [30]. In this study, 4% of prescriptions presented with unreadable handwriting, 15% included abbreviations, and only 1% did not included details about administration of the medication. The use of abbreviations can mislead the commercialization of the drug or interpretation of information regarding drug administration by the patient, which may be harmful to its health [22].

A study conducted by Sano et al. [31] evaluated the understanding of pediatric prescriptions by accompanying patients and found that 59% of them could not understand the prescriptions due to unreadable handwriting.

The risk factors for health care during the dental visit were also a reason of warning (e.g. increased number of diagnoses and medications by a patient), and were significantly correlated with the illegibility of prescriptions. This might due to the fact that patients with complicated medical profiles are at increased risk of severe adverse effects if an incorrect prescription is dispensed, as well as a potential risk of drug interactions or contraindications.

In our study, we also found errors related to dentist's identification, including 5% of prescriptions without signatures, and 66% without stamp. These items are considered to be critical and should appear in prescriptions even when the prescription paper contains an emblem of the college, school or university [6].

Prescriptions should be provided in two copies, and the second one should be signed by the patient towards being filed with its dental records after the inclusion of date and dentist's signature as suggested for fit notes [32]. In this study, 36% of prescriptions did not include a copy obtained using an interleaving carbon-paper sheet. Hence, they might not necessarily correspond to the original document delivered to the patient as previously mentioned.

The absence of patient or its guardian's signature was the error which presented with highest frequency among the prescriptions analyzed (88%). This percentage was also above the average found by Brito [16] in a survey of professionals, which recorded 9.4% of prescriptions filed without patient's signature. This is considered another significant error as, in case a patient's dental record is requested for consultation by justice, there will be no evidence that the patient received a copy with same content of the original prescription, and it can lose then its juridical value.

Therefore, it was observed that last-year dental students of the researched institution still have many difficulties in the preparation of fit notes and prescriptions, which lead them to commit several errors, including the awareness of which items are required for their composition, the purposes of such items, and the need for their filing. Most students appear to be unaware of ethical and legal principles for

managing the documents which compose the dental records. According to previous data, this survey is not an isolated fact, as similar failures were observed in the management of dental records in other institutions [5,17].

It is noteworthy that higher education institutions play a key role in raising awareness of the relevance of a well-elaborated documentation. Yet, this is the time when the future professionals become aware of this, developing thus good professional habits [33].

From the educational point of view, the fulfillment of records is the first contact of dental students with patients, making it the best chance for the professor to provide orientation to students in terms of professional behavior, respect for the patient's dignity, and the communication process between patients and practitioners. In addition, the constant and supervised exercise helps to pin knowledge, raising awareness about its importance, as well as it leads the future dentist to develop an automatic attitude towards filling out the records, a daily practice which many clinicians have difficulty in developing [7].

On the other hand, one reason to encourage professionals to be concerned about the correct preparation of records is the knowledge of people who are learning to exercise their rights; this can elevate the relationship between dentists and patients from a trust to a contractual relationship [34].

Yet, although patients as holders of dental records may request them for various reasons, the records' copyright belongs to the professional who prepared it; hence, it is very important that the documentation is prepared and filed correctly [15].

Finally, we draw attention to the fact that this study was conducted from documents filed by undergraduate students, unlike other studies cited here with results obtained by professional dentists, and who are still under the supervision teachers who should be aware of all the legal details for the issue of such documents. Thus, the errors found in this survey may be associated with lack of adequate or even update by teachers responsible under current legislation monitoring. In this sense, educate teachers about the observation of laws and integrate knowledge among the various disciplines of the course, which they considered as clinical sciences or basic sciences like pharmacology, it is a pressing need for better training of new professionals. On the other hand, it is up to educational institutions program update courses, retraining and continuing education in such topics relevant to professional training as addressed in this study so that the entire faculty is aligned on the standards for the preparation of certificates and recipes.

Conclusions

Considering the failures observed in relation to the preparation of fit notes and prescriptions by last-year dental students, we highlight the importance of the professor in providing support, updates and orientation towards a better development of these documents. The goal is students to become aware that this activity is also a component of a



good dental practice, as well as the ethical and legal aspects related to the clinical practice and respect for patients.

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