

Dental Referral Checklist - Before Radiation Therapy

Patient Name _____ Patient telephone _____

Referring physician _____

Preparation			
Checklist Items	Required Now	After Radiation	Comments
Dental Cleaning and evaluation prior to commencement of Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	
Fabrication of fluoride carriers	<input type="checkbox"/>	<input type="checkbox"/>	
Removal of teeth hopeless / infected / broken teeth should be removed 10 days prior to radiation	<input type="checkbox"/>	<input type="checkbox"/>	
Fabrication of mouth opening tongue depressing stent	<input type="checkbox"/>	<input type="checkbox"/>	
Fabrication of tongue deviating parotid stent <input type="checkbox"/> with NO shielding <input type="checkbox"/> with "LEAD" shielding Radiation is to: <input type="checkbox"/> Right side <input type="checkbox"/> Left side	<input type="checkbox"/>	<input type="checkbox"/>	
Please call radiation team when you see patient.	<input type="checkbox"/>	<input type="checkbox"/>	