

STEM CELL TRANSPLANT PROGRAM

76 Stuart Street

Kingston, ON K7L 2V7

Phone: 613-549-6666 Ext. 6627

Fax: 613-548-2499

Email: kghstemcell@kgh.kari.net

Dental Examination Request

Date: _____(yyyy/mm/dd)

Dear Dr. _____,

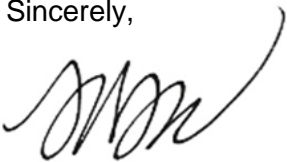
We have a mutual patient who is preparing to undergo an Autologous Stem Cell Transplant on _____(yyyy/mm/dd).

To maximize the safety of this procedure, we request a recent dental examination to be completed to assess for any periodontal infections. A thorough dental exam is necessary, including recent radiographs, to exclude the presence of infection prior to transplant.

All dental work must be completed and healed prior to moving forward with a transplant. Please refer to the examination report checklist provided for the requested information. Please forward the completed report checklist and any addition information, as necessary, to the above listed contact information.

Thank you in advance for your assistance, your expertise in this regard is greatly appreciated. We look forward to hearing from you soon.

Sincerely,



Dr. Sita Bhella
Stem Cell Transplant Program
Kingston Health Sciences Centre

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Instructions: Please complete the following report checklist for your dental examination and radiograph findings. Please send a completed copy to the Stem Cell Transplant Program at Kingston Health Sciences Centre by **Fax: 613-548-2499**. If any additional information is required, please do not hesitate to contact us.

Thank You.

Patient Name: _____		
Date of Birth: _____		
Date of Examination: _____		
Evaluation of oral cavity completed:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Routine dental prophylaxis/cleaning has been completed within the past six months:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Panorex or bitewing X-ray completed:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Presence of infection or dental abscesses:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Presence of dental caries:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Presence of active gingival or mucosal lesions:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Evidence of significant risk for breakdown or infection within the next 3 – 6 months:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the patient require urgent or major dental treatment: (e.g. root canal or dental extraction)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If extensive dental repairs/extractions are required, please indicate the scheduled dental treatment date(s). We will delay the preparative (mobilization) regimen until at least one week following any extractions or major dental treatment (longer if complications arise or if otherwise advised by you).		
Scheduled Dental Treatment Visit(s):		
Date: _____	Procedure: _____	
Date: _____	Procedure: _____	
Additional Comments: <i>or provide a copy of examination/radiograph report findings</i>		

I, Dr. _____, have assessed the patient's oral and dental health.		
Printed Name		
I have deemed them clear of any signs or symptoms of infection.		
<input type="checkbox"/> Yes		
<input type="checkbox"/> No		
_____	_____	_____
Signature	Date (yyyy/mm/dd)	Time (hhmm)