Kingston General Hospital

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

Kingston General Hospital

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

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:	☐ Yes	☐ No
Routine dental prophylaxis/cleaning has been completed within the past six months**:**	☐ Yes	☐ No
Panorex or bitewing X-ray completed:	☐ Yes	☐ No
Presence of infection or dental abscesses:	☐ Yes	☐ No
Presence of dental caries:	☐ Yes	☐ No
Presence of active gingival or mucosal lesions:	☐ Yes	☐ No
Evidence of significant risk for breakdown or infection within the next 3 – 6 months:	☐ Yes	☐ No
Does the patient require urgent or major dental treatment: (e.g. root canal or dental extraction)	☐ Yes	☐ 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: *or provide a copy of examination/radiograph report findings*

_____
_____
_____

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.

☐ Yes
☐ No

_____	_____	_____
Signature	Date (yyyy/mm/dd)	Time (hhmm)