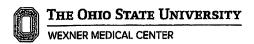
Dental Clearance Checklist for Head and Neck Cancer Patients

- Dental Disease Factors
 - condition of the current dentition
 - tooth condition
 - mild to moderate dental caries: restore with composite or GI
 - moderate dental caries: consider root canal pretreatment (if time allows)
 - severe dental caries: extract
 - periapical infection: root canal with crown or extract
 - periodontal bone loss: immediate perio therapy or extract
 - perio conditions with POOR prognosis—> extraction
 - teeth with > 5mm perio pockets
 - teeth with furcation involvement
 - teeth with perio abscesses
 - teeth with moderate to severe mobility
 - fractured teeth: extract
 - dental compliance of the patient (home care and in-office care)
 - maxillary vs mandibular teeth (must be more aggressive/proactive in mandible)
- Removable Prosthodontics
 - Lingual and Palatal Tori: if fully dentate do not remove, if partially dentate then consider removal or lingual plate RPD, if completely edentulous or planned must remove all tori prior to cancer treatment
- Completely Edentulous patients: assess for root tips, impacted teeth with infection or partially impacted teeth with any exposure into the oral cavity
- Timing and priority of pre-radiation treatment:
 - 1. extractions 2. root canals & perio 3. dental fillings 4. dental cleaning
- Dental Maintenance: topical fluoride, oral hygiene instructions, professional cleaning every 3-4 months with regular follow-ups, anti-plaque mouthwash, diet low in sugars with reduced snacking
 - Topical Fluoride: 1% SODIUM FLUORIDE or 0.4% stannous fluoride gel
 - APF acidulated phosphate fluorides are not recommended
 - Dry Mouth Products: mouthwash (biotene, cloSYS), tablets (XyliMelts), gel (GC Dry Mouth Gel)

OSU CCC JAMES H&N Main Line: 614-293-8074 Radiation Oncology: 614-293-8415 (for clearance)

email Dr. Sasha Valentin, DDS: sasha.valentin@osumc.edu

The James



Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Richard J. Solove Research Institute

Radiation Oncology

410 West 10th Ave Columbus, OH 43210 614-293-8415 Phone 614-366-8707 Fax

HEAD AND NECK RADIATION ONCOLOGY DENTAL CONSULT

We have performed a comprehensive dental examination on	(patient
with DOB of Date of exam was	
Due to the risk of osteoradionecrosis of the jaw seen with this treatment, we ask the patient provide the following dental services:	's dentist to
 Detailed baseline dental exam to include: Panoramic film, full mouth series or comb beam CT for baseline assessment/p dentition. 	rognosis of
 b. Comprehensive periodontal evaluation. c. Edentulous patients should receive a dental assessment including panoramic screen for retained teeth and occult lesions not clinically evident. 	radiograph to
 Extract all unrestorable teeth or any tooth with a poor or hopeless prognosis Consider these guidelines for dental extractions: 	
 a. Full mouth extractions may be indicated in patients who cannot or will not co dental health care practices. b. Extractions are indicated in areas of severe periodontal bone loss, whether loss 	calized or
generalized. Proper periodontal treatment generally involves too much time a predictably provide the desired pre-therapy state of stable oral health. c. Extraction would be indicated for any teeth with periapical pathology that car	and variability to
timely, appropriate endodontic therapy. 3. Assess appliances (complete/partial dentures) for proper fit. Remove/reduce sources friction.	
 Oral Hygiene program: Instruct on proper brushing, flossing, and frequency of care. Return to office appointments for oral health monitoring and assessment of oral hygie Schedule return visits at 3 to 6 month frequency as is most appropriate for this Repeat films if a problematic situation exists which the dentist feels is appropiate. Reassess for good appliance fit Assess compliance with oral hygiene program 	is patient
TO BE COMPLETED BY THE DENTIST PERFORMING THE BASELINE EXAM:	
Patient has adequate/stable oral health and may initiate radiation therapy	
Patient will require extraction/further invasive procedure; following procedure wait 2-4 week healing process is completed to initiate radiation therapy	ks until the
Scheduled treatment date(s):	
Dental Provider's Signature: Date:	
Dental Provider's Name (print): Ph#:	
PATIENT'S RADIATION ONCOLOGIST:	

PLEASE FAX CLEARANCE FORM BACK TO RADIATION ONCOLOGY ALONG WITH ANY DENTAL REPORTS.