Dental Care for Radiation Oncology Patients

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mint. *

dental studio

Patient Info:

Patient Name _____ Date _____

Hospital # _____ Patient Birthdate _____

Phone (primary) _____ Referring Provider _____

Phone (alternate) _____ Contact # or Email _____

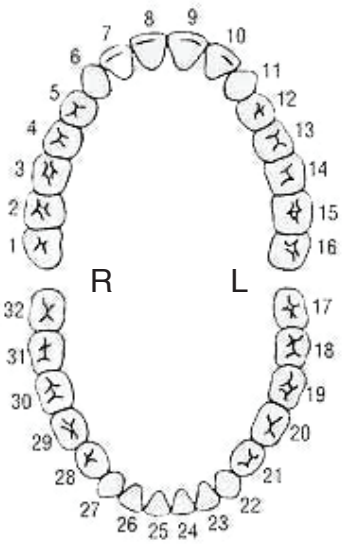
Urgency
- ☐ < 48 hrs (please call Mint*)
- ☐ < 2 wks
- ☐ < Routine

Tumor Type:
- ☐ Squamus Cell
- ☐ Adenoid Cystic
- ☐ Other _____

Tumor Location: ☐ R ☐ L _____

Radiation type(s):
- ☐ Photon
- ☐ Neutron
- ☐ Electron
- ☐ Other _____

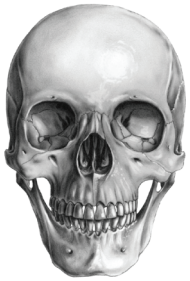
Reason for referral:
- ☐ Pre-RT clearance
- ☐ Post-RT F/U
- ☐ Other _____

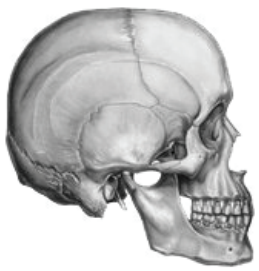


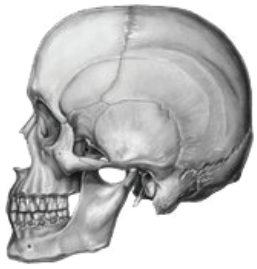
Expected Salivary Sparing:

(100% = fully spared, 0% = sacrificed)

	R	L
Parotid	_____	_____
Submandibular/ Sublingual	_____	_____







Thank you for your referral!

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