DANA-FARBER/BRIGHAM AND WOMEN'S

CANCER CENTER

Division of Oral Medicine and Dentistry, Brigham and Women's Hospital

COVER SHEET

Dear Provider,

Please review and complete all the attached materials for your patient who is a prospective candidate for head and neck radiation therapy.

PLEASE ENSURE YOU HAVE ENCLOSED THE FOLLOWING:

- ☐ Completed 3-page evaluation form
- ☐ Completed 1-page treatment plan
- ☐ Complete full mouth radiographs **ONLY**
- ☐ Panoramic radiograph (if indicated)

PLEASE RETURN THE EVALUATION AND DENTAL FILMS IMMEDIATELY:

A) If you use digital films:

- Email this report and films to: bwhoralmedicine@partners.org. Please put the patient's full name and date of birth in the subject header (e.g: Smith, John 1.1.1955). Please also indicate "H&N" in the subject line for "head and neck"; OR
- Fax this report to 617-264-6312 and Email films to bwhoralmedicine@partners.org

B) If you use non-digital films:

- Email this report to: bwhoralmedicine@partners.org. Please put the patient's full name and date of birth in the subject header (eg: Smith, John 1.1.1955). Please also indicate "H&N" in the subject line for "head and neck".
- OR FAX this report to 617-264-6312.
- Send non-digital films BY OVERNIGHT MAIL to: Division of Oral Medicine and Dentistry, Attn: Head and Neck Coordinator, 75 Francis Street, Boston, MA 02115.
- Please keep a copy of the radiographs for your files and send us the originals since we will not be returning the films to you.

Please contact us at bwhoralmedicine@partners.org if you have any questions or would like to speak with one of the Oral Medicine specialists.

Thank you,

Sook-Bin Woo, DMD, MMSc
Hani Mawardi, DMD, MSc
Nathaniel Treister, DMD, DMSc
Alessandro Villa, DDS, MPH, PhD

HEAD AND NECK CANCER THERAPY DENTAL EVALUATION

Please complete EVERY portion of this form

Patient's Name: _____

Patient's Address: _____

Date of Birth (DD/MM/YYYY):_____

Examiner's Name: _____

Examiner's Address: _____

Examiner's Phone No.: ( ) _____

Patient has been part of your practice since _____ (year)

Patient's cancer diagnosis _____

Patient's Past Dental History: Please comment if you circle Y.

Y N Periodontal therapy _____

Y N Endodontic therapy _____

Y N History of pericoronitis _____

Y N Removable prosthesis _____

Date of enclosed radiographs _____

(If you use digital films, please Email them to: bwhoralmedicine@partners.org. If you use non-digital films, please make a copy of radiographs for yourself as these will not be returned to you.)

Extra-oral Examination _____

Division of Oral Medicine and Dentistry, Brigham and Women's Hospital, 75 Francis Street, Boston, MA 02115, (617) 732-6974

Intra-oral Examination:

Y N Symptomatic teeth _____

Y N Soft tissue lesions _____

Y N Caries _____

Y N Fractured or defective restorations _____

Y N Vitality testing (any tooth with large restorations)
_____

Y N Percussion sensitivity _____

Y N Areas of gingival bleeding on provocation
_____

Y N Teeth with pockets >4 mm _____

Y N Teeth with mobility greater than Grades 2 or 3 _____

Y N Areas of suppuration/fistulae/sinus tract _____

Y N State of removable prosthesis _____

Y N Third molars present _____

Location of distal gingiva on #17 circle one occlusal 1/3 mid 1/3 cervical 1/3
Location of distal gingiva on #32 circle one occlusal 1/3 mid 1/3 cervical 1/3

If occlusal 1/3, please comment on distal pocketing, symptoms and appearance of gingival tissues in the area_____

Amount of plaque present: None slight moderate heavy
Amount of calculus present: None slight moderate heavy
Your rating of home care: Poor Fair Good Excellent

Periodontal disease classification: ADA I II III IV

Radiographic findings:
Presence of apical lucencies: _____

Other findings (clinical and radiographic):
_____

Treatment Plan

Dates: Procedures:

_____
_____
_____
_____
_____
_____

Scaling and Prophylaxis (date completed): _____
This must be within the last three months

Thank you.

_____
Signature of examiner

_____
Name of examiner

General practice or Specialist: _____

_____
Date of evaluation

PLEASE RETURN THIS EVALUATION WITH DENTAL FILMS (IF NON-DIGITAL) IMMEDIATELY BY OVERNIGHT MAIL TO THE PERSON NAMED ON THE ENVELOPE PROVIDED. IF NO ENVELOPE IS PROVIDED, PLEASE RETURN THE FORMS TO BRIGHAM AND WOMEN'S HOSPITAL, ATTN: HEAD AND NECK COORDINATOR, 75 FRANCIS ST., BOSTON, MA 02115

Rev. 4/2016