



# SEATTLE SPECIAL CARE DENTISTRY™

Bart Johnson, DDS, MS

Amy Winston, DDS

Patient Name: \_\_\_\_\_  
Hosp #: \_\_\_\_\_  
Phone (primary): \_\_\_\_\_

Date: \_\_\_\_\_  
Birth date: \_\_\_\_\_  
Phone (alt.): \_\_\_\_\_

Referring Provider: \_\_\_\_\_

Contact #/E-mail: \_\_\_\_\_

Urgency:  < 48 hrs (please call SSCD)  < 2 wks  Routine

Tumor type:  Squamous Cell  Adenoid Cystic Other: \_\_\_\_\_

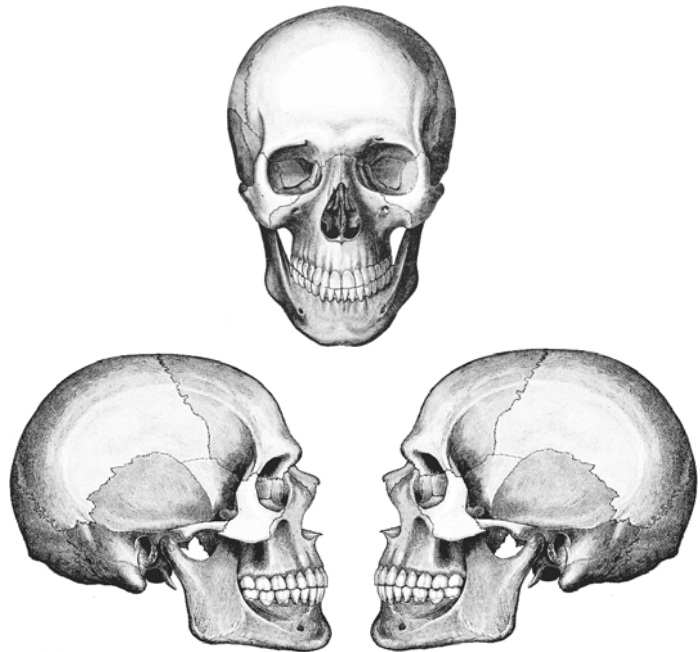
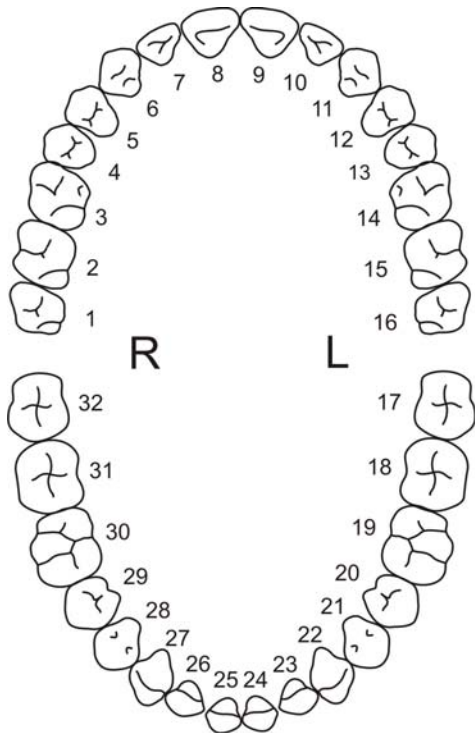
Tumor location:  R  L \_\_\_\_\_

Radiation type(s):  Photon  Neutron  Electron  Other: \_\_\_\_\_

Reason for referral:  Pre-RT clearance  Post-RT F/U  Other: \_\_\_\_\_

Tongue Deviating Stent:  
 To the Left  To the Right  Downward Interincisal opening (mm): \_\_\_\_\_

Please Mark appropriate dose fields:



Expected Salivary Sparing: (100% = fully spared, 0% = sacrificed)

	Right	Left
Parotid	_____	_____
Submandibular/Sublingual	_____	_____

Thank you for your referral!

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[www.seattlespecialcaredentistry.com](http://www.seattlespecialcaredentistry.com)