SEATTLE
SPECIAL CARE DENTISTRY

Amy Winston, DDS Noah Letwin, DDS, PhD Lauren Vainio, DDS Aarika Mitchell, DMD

Patient Name: _____ **Date:** _____

Hosp #: _____ **Birth date:** _____

Phone (primary): _____ **Phone (alt.):** _____

Insurance Company: _____ **Subscriber Name/ ID:** _____

_____

Referring Provider: _____ **Contact #/Email:** _____

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

Tumor type: □ Squamous Cell □ Adenoid Cystic □ Other _____

Tumor location: □ R □ L _____ **ICD 10 Code:** _____

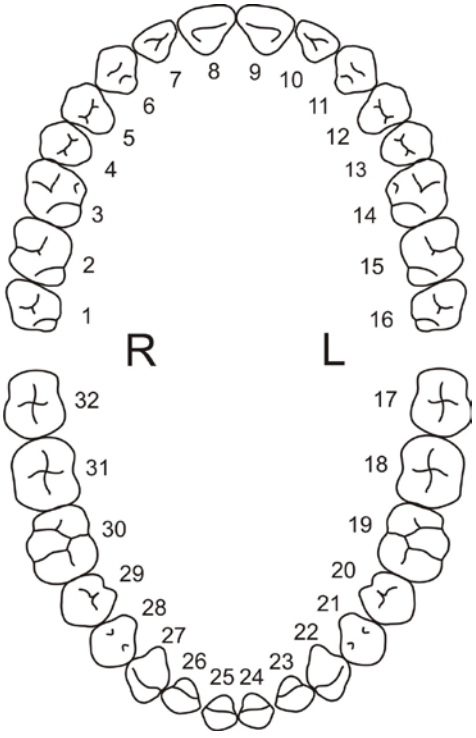
Radiation type(s): □ Photon □ Neutron □ Electron □ Proton

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

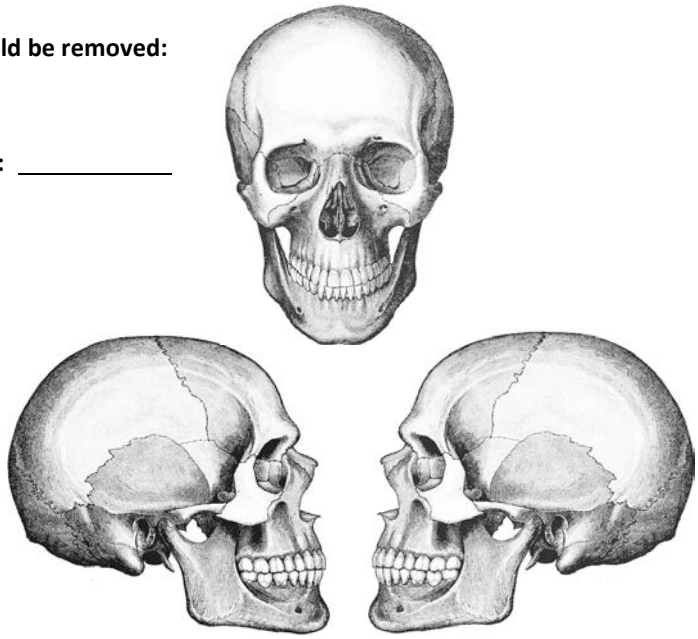
□ Grayduck Stent: □ Standard Stent: □ Stent to be completed at radiation department

□ To the Left □ To the Right □ Downward **Interincisal opening (mm):** _____

Please Mark appropriate dose fields:
Please place "X" over teeth from which metal should be removed:



Sim Date: _____



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

	Right	Left
Parotid	_____	_____
Submandibular/Sublingual	_____	_____

Thank you for your referral!

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