DENTAL ASSESSMENT FORM: PRE-TREATMENT HEAD AND NECK CANCER

Patient Information

Patient Name:	**Phone #:**	**DOB:**	**Gender:** ☐ M ☐ F
Primary Diagnosis: **Location** _____**Stage** _____ **Field** _____	**Planned Treatment:** ☐ *TBD – Please call NN for info* ☐ Surgery ☐ Chemotherapy ☐ Radiation ☐ Needs Obturator **Field:**_____		
Nurse Navigator: **Kim Moses, RN, BSN, OCN** **Ph: 360-788-8234 / Fax: 360-752-6015** **kmoses@peacehealth.org**	**Treating Doctor(s):** ☐ *TBD – Please call NN for info* Surgery Medical Oncology Radiation Oncology		
☐ **Labs Alert**:	☐ **Special Instructions:**		

Dentist Information

Dentist Name and Address:	Practice Type: ☐ General Dentistry ☐ Specialty: _____	
Dentist Phone:	Dentist Fax:	Dentist email:

Dental Exam Completed on: _____/_____/_____

Chief Complaint:	Prior Dental Health History ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Radiographic Findings:	X-rays consulted: ☐BW ☐PA ☐FMX ☐Pano

Extra-oral Exam:

General Survey (asymmetry, nodes, etc.) ☐ WNL ☐ ABN:

TMJ Range of Motion ☐ WNL ☐ ABN: **TMD concerns**:

Intra-oral Exam

Soft Tissue ☐ WNL ☐ ABN:	**Saliva**: ☐ WNL ☐ ABN (xerostomia, thick saliva, etc.) Flow rate: UWS: ____mg/min SWS: ____mg/min
Periodontal Assessment ☐ WNL ☐ ABN:	**Oral Hygiene**: ☐ Poor ☐ Fair ☐ Good ☐ Excellent
Dentition ☐ WNL ☐ ABN:	
Caries Rate: ☐ Low ☐Medium ☐High	☐ Prosthetic Needs:

Dental Referrals:

☐ **Perio** ☐ **Endo** ☐ **Oral Surgery** ☐ **Oral Medicine** ☐ **Other** ☐ **N/A**

Referred to:

Pre-Radiation Therapy/Surgery Needs	**Post-Radiation Therapy/Surgery Needs**
1.	**1.**
2.	**2.**
3.	**3.**
4.	**4.**

Target Date to Complete Pre-Radiation Therapy/Surgery Dental Treatment: _____

Progress:

1. ☐ **Dental exam and Trx Planned.** ☐ **Sent to Nurse Navigator on** ___/____/____ **by** _____
2. ☐ **Dental Trx Complete. Anticipate complete healing by** ___/____/____ ☐ **Sent to Nurse Navigator on** ___/____/____