UW Medicine

UNIVERSITY OF WASHINGTON
MEDICAL CENTER

To Whom It May Concern:

Your patient is undergoing an evaluation for transplantation. As a routine part of the evaluation, patients are required to have a current assessment of their dental health. Patients need to be cleared for any dental abscess or infection. Please complete the following when the assessment is complete and send to:

UWMC Kidney/Pancreas Transplant Services
1959 NE Pacific Street, Box 356174
Seattle, WA 98195

FAX to (206) 598-2201

Dental Clearance for Pre-Kidney Transplant Evaluation

Patient Name: _____________________ Date of Birth: ___________

1. Dental Condition: GOOD FAIR POOR

2. Are teeth and gums free of infection? YES NO

3. If no, what is the treatment plan?

4. Date of Exam: _________________________________

Dentist Name (printed):____

Dentist Signature:____

Office Phone Number: ____

** After transplant, patients should receive antibiotic prophylaxis as recommended by the American Heart Association.