Hartford Hospital
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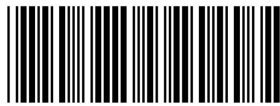

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HARTFORD HOSPITAL LIVER TRANSPLANT PROGRAM

Dental Evaluation and Clearance

Your patient ___________________________/ DOB: ______________ is being evaluated in the Transplant Program. Identification and treatment of any pre-existing dental conditions that may be potential sources of infection are crucial to the transplant evaluation process. Thank you for assisting us in the evaluation process. Please fax this form back to the appropriate program below. If you have any questions or concerns please do not hesitate to call us (see contact information below for appropriate program).

☐ Liver Transplant Program phone number 860-972-4219; Fax 860-545-4146

TO BE COMPLETED BY THE DENTIST

Type of Transplant Evaluation: ☐**Liver**

Diagnoses:

Gingivitis: ☐Mild ________ ☐Moderate _________☐Severe ______________

Periodontitis: ☐Mild ________ ☐Moderate _________☐Severe ______________

Teeth with caries that are restorable: ____

Teeth with deep caries that require root canal therapy: ____

Teeth require extraction before transplant surgery: ____

☐Up to date with prophylaxis and treatment

For Liver Patients only: **MELD Score**________________ **Plts**________________**INR**________________

Does you evaluation reveal caries, periodontal disease or Dental health issues requiring intervention?	☐Yes ________ ☐No ________ Intervention:
Is the dental disease too severe to safely undergo transplantation and immunosuppression?	☐Yes ________ ☐No ________
Is there evidence of an active infection? (i.e. fever, swelling, or increased wbc)	
If intervention is delayed, when do you wish to reevaluate the patient post-transplant?	☐3 months________ ☐6month ________ ☐other________

Is this patient cleared for transplant? _______________________________________

Comments: ____

____

Dentist Signature:___________________________________ Date: ________________ Time:____________

Print Name: ___________________________________ Tel: ____________________________