

Dental Clearance for Pre-Kidney Transplant Evaluation

To Patient: Please give form to your dental provider.

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 98195-6174

FAX to (206) 598-2201

Dental Clearance for Pre-Kidney Transplant Evaluation

Patient Name: _____ DOB: _____

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

2. If no, what is the treatment plan?

3. Date of Exam: _____

Dentist Name (printed): _____

Dentist Signature: _____

Office Phone Number: _____ Office Fax Number: _____

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

PLACE PATIENT LABEL HERE

UW Medicine
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