

Dentist Name: _____

Dental Office: _____

Patient _____ DOB _____ is undergoing an evaluation for heart transplantation. As a routine part of the evaluation, patients are required to have a current assessment of their dental health and completion of recommended dental intervention. The goal is to eliminate potential sources of infection, making transplant as safe as possible for the patient.

- Date of last dental exam with current radiographs: _____
- To proceed with heart transplant evaluation or listing, please confirm the following:
 - No extractions needed
 - No untreated endodontic/periapical infections
 - No untreated large carious lesions or fractures that could lead to dental infection
 - No deep cleaning needed to address severe periodontal disease
 - No severely loose teeth

Please check the appropriate boxes:

Dental health cleared for Heart Transplant procedure

Dental Health **NOT** cleared for Heart Transplant procedure

Exam findings and recommendations: _____

Dental Work to be completed by:

Me - Expected Date of Completion: _____

Other: _____

Dentist Signature: _____ Date: _____

Please return this form via fax to (612) 863-3646