Amy Winston, DDS   Noah Letwin, DDS, PhD   Lauren Vainio, DDS   Salma Helal, DDS

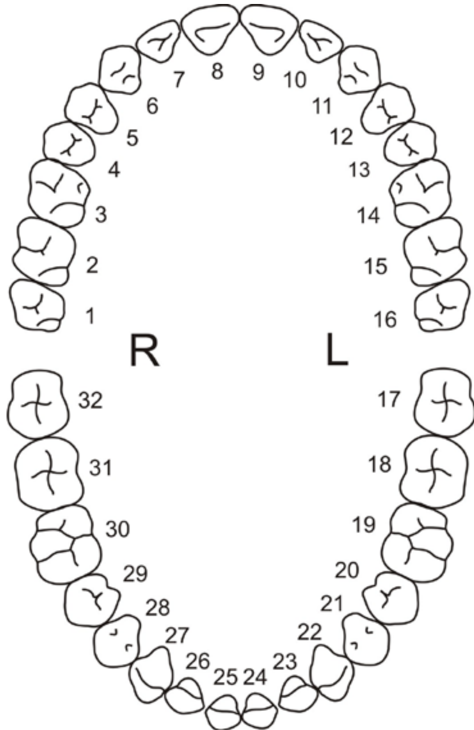
Patient Name: ______________________ **Date:** ______________________
Hosp #: ______________________ **Birth date:** ______________________
Phone (primary): ______________________ **Phone (alt.):** ______________________
Insurance Company: ______________________ **Subscriber Name/ ID:** ______________________

____

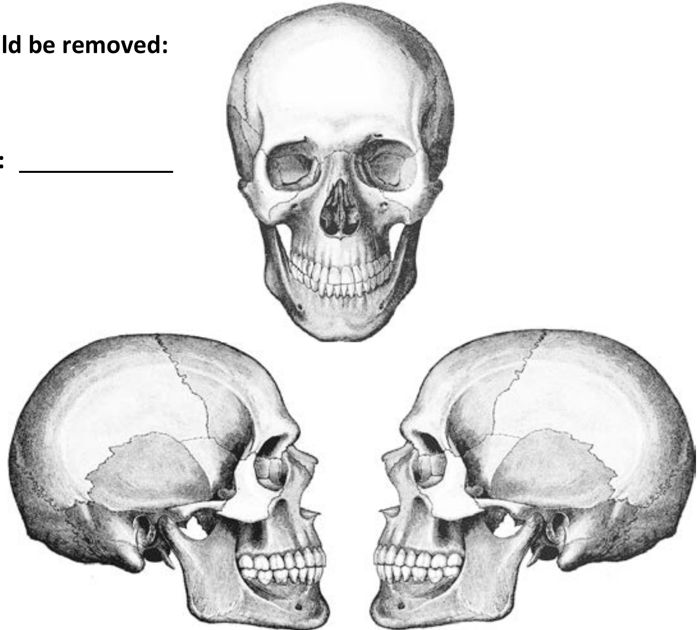
Referring Provider: ______________________ **Contact #/Email:** ______________________
Urgency: □ < 48 hrs ***(please call SSCD)*** □ < 2 wks □ Routine

Tumor type: □ Squamous Cell □ Adenoid Cystic □ Other ______________________
Tumor location: □ R □ L ______________________ **ICD 10 Code:** ______________________
Radiation type(s): □ Photon □ Neutron □ Electron □ Proton
Reason for referral: □ Pre-RT clearance □ Post-RT F/U □ Other: ______________________
□ Grayduck Stent: □ Standard Stent: □ Stent to be completed at radiation department
□ To the Left □ To the Right □ Downward **Interincisal opening (mm):** ________

Please Mark appropriate dose fields:
Please place "X" over teeth from which metal should be removed:



Sim Date: ____________



Expected Salivary Sparing: (100% = fully spared, 0% = sacrificed)

	Right	Left
Parotid	________	________
Submandibular/Sublingual	________	________

Thank you for your referral!

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206-524-1603 (Fax)
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