SEATTLE
SPECIAL CARE DENTISTRY™

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:** _____

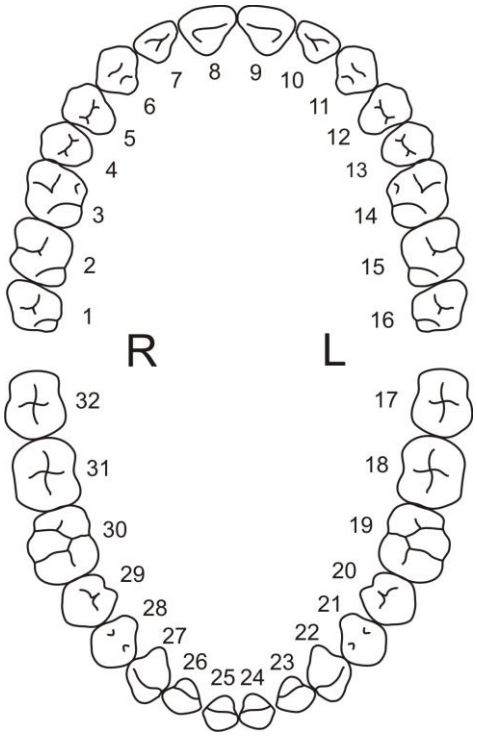
Radiation type(s): □ Photon □ Neutron □ Electron □ Other: _____

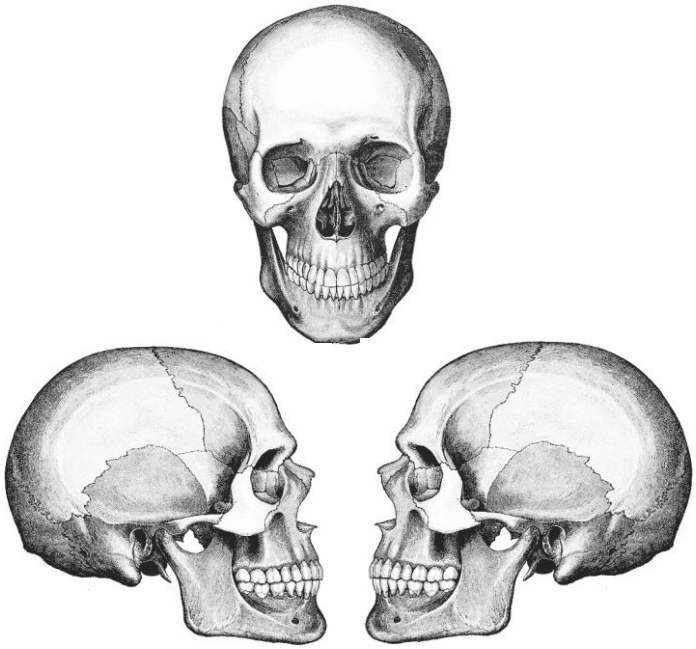
Reason for referral: □ Pre-RT clearance □ Post-RT F/U □ Other: _____

□ Tongue Deviating Stent:

□ To the Left □ To the Right □ Downward Interincisal opening (mm): _____

Please Mark appropriate dose fields:





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

	Right	Left
Parotid	_____	_____
Submandibular/Sublingual	_____	_____

Thank you for your referral!

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