Dental Clearance for Transplant Evaluation

Date: ______________ Patient Name: ____________________________ DOB: ___________

This patient is scheduled to undergo an evaluation for organ transplantation. Due to immunosuppressant medications patients receive after their transplant, it is imperative for the transplant center to receive documentation that the patient has no known source of infection or malignancy. Any infection or malignancy must be corrected and documented.

Please indicate if this patient is free of abscesses or moderate to severe periodontal disease. Information must be within the last 12 months.

Thank you for your assistance.

Exam Findings and Recommendations (forward reports as applicable)

Date of Exam: _________________________

Findings of Dental Exam: ____

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Dental Work Recommended: ____

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Dentist Name (please print): ____

Dentist Signature: ____

Office Name: ____

Office Phone: _________________________ Office Fax: _____________________________

Please send/fax results to:

Nebraska Medicine
983285 Nebraska Medical Center
Omaha, NE 68198-3285
Phone: 402-559-5000
Fax: 402-559-8902

Revised January 2016