Special Needs Dentistry Australia

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REFERRAL FORM FOR ONCOLOGY PATIENTS

PATIENT DETAILS

Full Name: Date of Birth:

Email: Contact Number(s):

Address:

REFERRAL DETAILS

Cancer Diagnosis & Staging:

Treatment modality:

☐ Radiotherapy only ☐ Chemotherapy only ☐ Chemo-Radiotherapy

☐ Surgery ☐ Post-operative Radiotherapy ☐ Immunotherapy

If chemotherapy/immunotherapy/other therapy (e.g. anti-resorptive therapy or bone marrow transplant), please specify:

Intent:

☐ Adjuvant

☐ Curative

☐ Palliative

Dental treatment required:

☐ Pre-therapy dental assessment ☐ post-radiotherapy on-going dental treatment/management

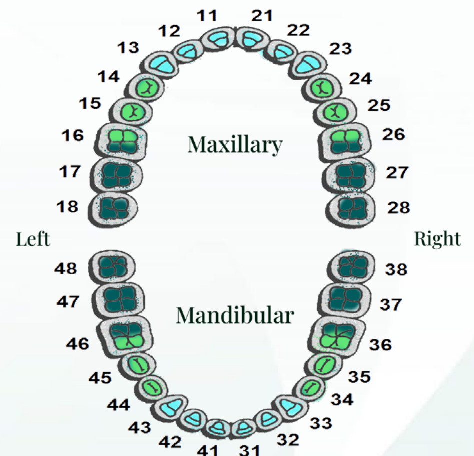
☐ Emergency dental treatment (please specify):

RADIOTHERAPY DETAILS (If applicable)

Date of radiotherapy commencement & completion:

Please specify (where applicable) the fields and dosages according to the relevant regions of the oral cavity:

Maxillary		Mandibular	
Region	**Radiation Dosage Range**	**Region**	**Radiation Dosage Range**
Anterior (13-23)		Anterior (33-43)	
Middle (RIGHT) (14-16)		Middle (RIGHT) (44-46)	
Posterior (RIGHT) (16-18)		Posterior (RIGHT) (46-48)	
Middle (LEFT) (24-26)		Middle (LEFT) (34-36)	
Posterior (LEFT) (26-28)		Posterior (LEFT) (36-38)	



If possible, please provide:

- Health summary from medical GP or specialist, including hospital discharge papers
- Medication list
- Most recent blood test date and results
- Oncology appointments (e.g. dates of stem cell collection, bone marrow transplant, radiation mask fabrication etc.)

ONCOLOGIST DETAILS

Referring clinician: Contact number:

Practice name: Email:

Signature: Date of Referral:

Please email referral and relevant documents to info@snda.com.au