Oregon Health & Science University
Hospitals and Clinics
Clinical Transplant Services
Liver Transplant Program
3181 SW Sam Jackson Park Road; L590
Portland, OR 97239-3098
503-494-8500 or 1-800-452-1369, EXT. 8500
FAX: 503-494-5292

TR3747

DENTAL CLEARANCE FOR PRE-TRANSPLANT EVALUATION

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

Patient: _____ DOB: _____

Dear Dental Professional,

Your patient is undergoing an evaluation for liver transplantation and needs a dental assessment to identify any serious active infections in the teeth or gums. Serious infection in the teeth/gums can prevent a liver transplant because of the significant immune suppression used in transplantation. Serious dental infections need to be treated/eradicated prior to transplant. Once the patient is listed for a liver transplant, an annual dental evaluation will also be required. Please complete the following and mail or fax it to our office.

1. Are teeth and gums free from serious, active infection? ☐ Yes ☐ No

2. If not, what is the recommended treatment to remedy the condition as a prelude to transplant:

   _____

   _____

   _____

3. Oral cancer screening performed and negative? ☐ Yes ☐ No

4. If extensive dental work is needed where there is a significant risk of bleeding, we suggest checking a CBC and PT INR and transfusion of 4 units FFP (if INR => 1.5), or 1 unit of pheresed platelets (for platelet count <=50); use irradiated products to prevent alloimmunization.

Dentist Name Printed and Credentials: _____

Dentist Signature: _____

Date of Dental Exam: _____

Practice Name: _____

Office Phone #: _____