ORAL HEALTH ASSESSMENT FOR CARDIO THORACIC PATIENTS

Patients Name: ....

Hospital Number: ....

Date Examined:..

Dental Surgeon (Name)..

Dental Surgeon (Address)..
(including telephone)

Teeth Present: ------------------------------/------------------------------

Is the patient dentally fit for cardiac surgery: YES/NO

If NO please indicate when patient will become dentally fit:……………………………………………

Any further comments or queries: ....