

The Royal Children's Hospital Melbourne
50 Flemington Road
Parkville Victoria 3052 Australia
TELEPHONE +61 3 9345 5522
www.rch.org.au



DENTALLY FIT FORM

PLEASE COMPLETE AND RETURN THIS FORM TO THE CARDIOLOGY DEPARTMENT

Cardiology Department

Tel: 61 3 9345 5713
Fax: 61 3 9345 6001
Cardio.Catheterteam@rch.org.au
[https://www.rch.org.au/
cardiology/parent_info/
Parent_information/](https://www.rch.org.au/cardiology/parent_info/Parent_information/)

Dentistry Department

Tel: 61 3 9345 5462
Fax: 61 3 9345 5488
reception.dental@rch.org.au
<http://www.rch.org.au/dentistry/>

Dear Dental Practitioner,

All children and adolescents who have cardiac disease should have regular dental check-ups. However it is particularly important prior to undergoing any cardiac surgery that they be seen by their local dentist and declared dentally fit before coming to the Royal Children's Hospital (RCH), Melbourne for their surgery.

DIAGNOSIS AND SCREENING:

1. A thorough head, neck, oral and dental examination to be carried out.
2. An OPG and bitewing radiographs should be taken as basic screening films whenever possible, with additional radiographs as required.
3. Oral hygiene instructions given to patients with emphasis on the importance of good oral health with respect to the prevention of infective endocarditis.
4. Treatment plans need to be developed in coordination with the medical/cardiac team.

A CHILD IS DEEMED DENTALLY FIT WHEN:

1. Carious teeth are restored and defective restorations replaced
2. Scaling and polishing has been carried out where necessary
3. Optimal oral hygiene is instituted
4. All pulpally involved primary teeth have been extracted
5. Any teeth which have acute or chronic infections and pathology be extracted at least 6 weeks before cardiac surgery and fillings to be done at least 2 weeks before cardiac surgery
6. Any orthodontic appliances and removable prostheses acting as potential irritants have been removed
7. All other oral pathology investigated and managed accordingly

I, Dr _____ of (address) _____

Declare that I have examined (patient) _____ and have rendered him/her dentally fit.

Date: _____

Signature: _____

If for any reason you have any queries about the oral health needs for this child or how to complete the required treatment please do not hesitate to contact the Department of Dentistry at the RCH.