Date: [Date]

To: [Oncologist Name / Department]
From: [Dentist Name / Clinic Name]
Patient Name: [Patient Name]
Patient Date of Birth: [Date of Birth]

Subject: Dental Clearance for Radiation Therapy

Dear Dr. [Oncologist Last Name],

I have performed a comprehensive clinical and radiographic dental evaluation of the above-named patient in preparation for their upcoming radiation therapy involving the head and neck region.

Clinical Findings:
The patient's oral health has been assessed with specific attention to potential sources of infection or irritation that could lead to complications such as osteoradionecrosis during or after treatment.

Clearance Status (Check One):

[ ] The patient is dentally fit to proceed with radiation therapy. No urgent dental treatment is required at this time.

[ ] The patient is cleared to proceed pending the completion of the following urgent procedures: [List Procedures, e.g., extractions of non-restorable teeth]. These procedures were/will be completed on [Date].

Recommendations:

- A healing period of [Number] days is recommended following extractions before radiation begins.
- The patient has been instructed on a strict oral hygiene regimen.
- Daily fluoride tray application [is/is not] recommended for this patient.

If you have any questions or require further information regarding this patient's dental status, please contact my office at [Phone Number].

Sincerely,

[Dentist Signature]
[Dentist Name, Degree]
[License Number]