

**NEWPORT CARDIAC & THORACIC SURGERY**

CARDIOVASCULAR AND THORACIC SURGERY  
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**Dental Evaluation**

**Before valve surgery:** Dental infections can allow bacteria into the blood stream, which can infect valves or suture lines in the heart. Because dental infections can compromise your heart surgery outcomes, an examination (without cleaning) of your teeth by a dentist is important before surgery. The surgeons request-that the dentist simply examine your teeth and gums but ***not perform routine teeth cleaning close to your surgery date.*** The surgeons believe this stirs up bacteria which can potentially infect your valve.

If dental work such as extractions, fillings, or root canals are indicated to clear you for surgery, please request these procedures be performed ***with antibiotic protection.***

**After valve surgery:** We prefer that you do not undergo elective dental procedures (such as dental cleaning) for **three months** following valve surgery. Obviously, urgent dental problems, such as toothaches, lost fillings, etc. should be treated by your dentist with antibiotic coverage.

**Life-long protection of your repaired or replaced valve:** For patients who have valve surgery, antibiotic coverage for dental procedures should always be used. Please get prescriptions for antibiotics from either your cardiologist or dentist.

**\*\*\*Please see your dentist as soon as possible BEFORE the surgery and have your dentist fax us this completed dental evaluation form.\*\*\***

THIS PORTION TO BE COMPLETED BY DENTIST  
AND FAXED TO 949-650-1274 AS SOON AS POSSIBLE

On \_\_\_\_\_ I conducted a dental examination on \_\_\_\_\_  
(Appt Date) (Patient's Name)

***\*\*Please check appropriate box(es)\*\****

I saw no indication of any gingival, periodontal or endodontic infections. From an oral aspect, I see no reason to delay any surgical procedure.

In my opinion, \_\_\_\_\_

\_\_\_\_\_ should be completed before surgery.

On \_\_\_\_\_ patient completed above dental work and is now cleared for surgery.  
(Appt Date)

\_\_\_\_\_  
Dentist's name (Please print) Dentist signature Date

\_\_\_\_\_  
Phone Number Dental office address

\_\_\_\_\_  
Dentist License Number