

ORAL HEALTH REFERRAL FORM FOR PREGNANT WOMEN*

PATIENT NAME
DOB
PRIMARY CARE PROVIDER

Patient ID / Addressograph

Date: _____ Referred to: _____

Reason for referral: Routine Bleeding gums Pain Other: _____

Weeks gestation (at time of referral): _____ Estimated delivery date: _____ Patient Phone # _____

This patient is cleared for routine evaluation and dental care, which may include but not be limited to:

- Dental x-rays as needed for diagnosis (*with abdominal and neck lead shield*)
- Oral health examination
- Dental prophylaxis
- Scaling and root planing
- Restoration of untreated caries
- Extraction
- Standard local anesthetic (*lidocaine with or without epinephrine*)
- Analgesics (if needed): Acetaminophen and/or Acetaminophen with codeine (*Nonsteroidal anti-inflammatory drugs are not recommended during pregnancy.*)
- Antibiotics (if needed and no known allergies): Penicillin, Amoxicillin, Cephalosporin, Clindamycin, Erythromycin-not estolate form (*Cipro and Tetracycline are not recommended during pregnancy*)

Significant Medical Conditions: NONE
 YES, (e.g.,
heart condition, liver disease, kidney disease, etc.)

Known Allergies: NONE
 YES

Drug(s)/Reactions(s): _____

Current Medications: NONE
 Prenatal Vitamins Iron Calcium
 OTHERS (*Attach updated list of active Rx with referral*)

Any Precautions: NONE
 SPECIFY (*List if any comments or instructions*): _____

Prenatal Care Provider (print name): _____

Phone/pager: _____ Fax #: _____

Signature: _____ Date: _____

Perinatal Care Provider:

1. Clerk or patient to call **Dental Clinic** for appointment 2. Fax referral form to **Dentist/Dental Clinic**. 3. Give copy of referral form to patient to bring to dentist. 4. Place one copy in patient's chart.

Dental Clinics:

Clinic A 123-9999 FAX (123-0987 phone)

Clinic B 456-9999 FAX (456-0987 phone)

Dentist: Please fax back information (to Prenatal Care Provider Fax # above) after initial dental visit:

Exam Date: _____ Normal exam/recall Missed Appt.

Needs additional treatment visits for: Caries Periodontitis Referral to Oral Surgery

Comments: _____

Dentist signature: _____ Date: _____