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: _____

Adapted from San Francisco General Hospital and Trauma Center, Community Health Network.