

# 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: \_\_\_\_\_