**Dental Referral** **Form for Pregnant Women**

**SECTION A: PRENATAL PROVIDER TO COMPLETE (SEND TO DENTAL PROVIDER)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Referred to:** | |  | | | | | | | **Referral Date:** |  | |  |
| *(Dentist Name | Practice)* | | | | | | | | |  | | |  |
| **Patient Information:** | | | | | | | | | | |  |  |
| Name: |  | | | |  |  | | | | |  | |
|  | *(Last)* | | *(First)* | | | | | | | |  | |
| DOB: | \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_\_ | | | Estimated Delivery Date: | | | | \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_\_ | | |  | |
|  | *mm dd yyyy* | | | *mm dd yyyy* | | | | | | |  | |
| **Known Allergies and Precautions:** *(Specify, if any)* | | | | | | |  | | | | | |
|  | | | | | | | | | | | | |
| **The following are considered safe during pregnancy:** | | | | | | | | | | | | |
| **Dental Procedures:**  Oral Examination  Dental Prophylaxis  Scaling and Root Planing  Extraction  Dental X-ray with Lead Shielding  Local Anesthetic with Epinephrine  Root Canal  Restorations | Fillings  **Patient may NOT have:** *(Specify)* | | | | | **Medications:**  Amoxicillin  Cephalosporins  Clindamycin  Metronidazole  Penicillin  Acetaminophen  Acetaminophen with Codeine, Hydrocodone, or Oxycodone | | | | | | | |
|  | | | | | | | | | | | | |
| **Referring Prenatal Provider** | | | | | | | | | | | | |
| Name: |  | | | | Signature: | | |  | | | | |
|  | *(Please Print)* | | | |  | | |  | | | | |
| Date: |  | | | | Phone #: | | | ( ) - | | | | |
| Email: |  | | | | Fax #: | | | ( ) - | | | | |

**SECTION B: DENTAL PROVIDER TO COMPLETE (RETURN TO PRENATAL PROVIDER)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Diagnosis:** | | | |  | |
|  | | | | | |
| **Treatment Plan:** | | | | |  |
|  | | | | | |
| **Dental Provider** | | | | | |
| Name: |  | Signature: |  | | |
|  | *(Please Print)* |  |  | |  |
| Date: |  | Phone #: | ( ) - | |  |

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