**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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