INSERT 2:

SAMPLE REFERRAL FORM FOR PREGNANT WOMEN TO ORAL HEALTH PROVIDERS

Referral Form for Pregnant Women to Recieve Oral Health Care

Referred To: _____ Date: _____

Patient Name (Last/First): _____

Date of Birth: _____ Estimated Delivery Date: _____ Week of Gestation Today: _____

Known Allergies: _____

Precautions: ___ None ___ Specify (if any): _____

_____

_____

Reason(s) for Referral: _____

_____

This patient may have routine dental care, including but not limited to: oral health examination, prophylaxis, scaling and root planning, extraction, dental x-ray with abdominal and neck shield, local anesthesia with epinephrine, root canal and restorations (amalgam or composite).

The patient may have: (Check all that apply)

__ Acetaminophen with codeine for pain control

__ Alternative pain control medication: (Specify) _____

__ Penicillin

__ Amoxicillin

__ Clindamycin

__ Cephalosporins

__ Erythromycin (not estolate form)

Prenatal Care Provider: _____ Phone: _____

Signature: _____ Date: _____

DO NOT HESITATE TO CALL WITH QUESTIONS

Dentist's Report for the Prenatal Care Provider

Diagnosis: _____

_____

Treatment Plan: _____

_____

Name: _____ Date: _____ Phone: _____

Signature of Dentist: _____