

**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 referral date) _____ 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 cavities
- 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 or, 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 for **Dental** 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 Provider: _____ FAX: _____ (phone): _____

Community Health Center Dental Clinics:

Interfaith: B'ham FAX (360) 671-3574 (phone 676-6177); Ferndale FAX (360) 303-0808 (phone 752-7140)

Sea Mar: B'ham FAX (360) 788-7131 (phone 738-3016); Mt. Vernon FAX (360) 428-5813; Burl. FAX (360)755-9205

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: Tooth decay/cavities Periodontitis Referral to Oral Surgery

Comments: _____

Dentist signature: _____ Date: _____

(if not above) FAX: _____ (phone): _____