DENTAL REFERRAL FORM FOR PREGNANT WOMEN

SECTION A: PRENATAL PROVIDER TO COMPLETE AND SEND TO DENTAL PROVIDER

Patient Referred to: _____ **Referral Date:** _____
(Dentist Name/Practice)

Patient Information:

Name: _____ _____ DOB: _____ _____ _____
(Last) *(First)* *mm dd yyyy*

Estimated Delivery Date: _____ _____ _____
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

Medications:
Amoxicillin
Cephalosporins
Clindamycin
Metronidazole
Penicillin
Acetaminophen
Acetaminophen with Codeine
Hydrocodone or Oxycodone

Patient may NOT have: Ciprofloxacin, Clarithromycin, Levofloxacin, Moxifloxacin, Tetracycline
(Specify any other)

REFERRING PRENATAL PROVIDER

Name: _____ Signature: _____
(Please Print)

Date: _____ Phone #: _____

Email: _____ Fax #: _____

SECTION B: DENTAL PROVIDER TO COMPLETE AND RETURN FORM TO PRENATAL PROVIDER

Summary of Findings/Diagnosis:

Treatment Plan:

DENTAL PROVIDER

Name: _____ Signature: _____
(Please Print)

Date: _____ Phone #: _____

If you are a Medicaid recipient, you can search for dentists at TMHP.com. If you are in Medicaid Managed Care, you can search for providers on your health plan's website, or call your health plan for assistance. If you have private insurance, you can contact your health plan for information and assistance. Many of the services are available to anyone, with or without insurance.

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