

Attachment 1

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 time of referral): _____ Estimated delivery date: _____ Patient phone: _____

Primary language spoken: _____

- ☐ This patient is cleared for routine evaluation and dental care, which may include but is not 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 caries
 - 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 disease, 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)

Any Precautions: ☐ NONE ☐ SPECIFY (List if any comments or instructions)

Prenatal care provider (print name): _____

Phone/pager: _____ Fax #: _____

Signature: _____ Date: _____

Dentist: Please fax information back (to prenatal care provider, fax # above) after initial dental visit:

Exam date: _____ ☐ Normal exam/recall ☐ Missed appointment

☐ Needs additional treatment visits for: ☐ Caries ☐ Periodontitis ☐ Referral to oral surgery ☐ Other _____

Comments: _____

Dentist signature: _____ Date: _____

Phone: _____

* Adapted from San Francisco General Hospital and Trauma Center, Community Health Network