Prenatal Dental Referral Prescription

Name of Prenatal Provider: 

Address: 

Phone: 

Fax: 

Date: ________________________________

Patient name: ________________________________________________

Reason for referral: □ exam and evaluation □ routine cleaning □ treatment

Patient’s dental concerns: □ pain □ swelling □ infection
□ possible gum disease □ possible tooth decay □ loose or broken tooth
□ no dental care in over one year □ other: ____________________________

Patient is approved for dental services including:
□ cleaning
□ x-rays with abdominal and thyroid shielding
□ extractions and fillings
□ local anesthesia (lidocaine preferred; etidocaine and prilocane also considered safe)
□ antibiotics (amoxicillin, penicillin, erythromycin (base), cephalosporins, clavulanate and clindamycin)
□ analgesia (acetaminophen preferred; acetaminophen with oxycodone for short term management of acute pain;
non-steroidal anti-inflammatory agents such as ibuprofen used with caution before the third trimester)

Weeks pregnant: _______________ Due date: ___________________

Significant medical conditions: __________________________________________________________

PPD result: __________ If positive, chest X-ray result: ______________

Current medications: ________________________________________________

Medication allergies: ________________________________________________

Signature of obstetric provider: ________________________________ Title: ________________