



## 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:** \_\_\_\_\_