Referral Form for Pregnant Women to Receive Dental Care

Referred to: ____ Date: ________________

Patient's Name: (First)___________________________________(Last): ________________

Known allergies: ____

Estimated delivery date: _________ Week of gestation today: _______

Precautions: ___ None

Specify if any: ____

____

Patient may have (check all that apply):

	Acetaminophen with codeine for pain control	
	Alternative pain control medication	Please Specify:
	Amoxicillin	
	Cephalosporins	
	Clindamycin	
	Erythromycin (not estolate form)	
	Penicillin	
	Local Anesthetic with epinephrine	
	Other, specify	

Name:___________________________________Date: ______________ Phone: ________

Signature: ____

Do not hesitate to call with questions

Adapted from: Kumar J, Samelson R, eds. (2006). Oral Health Care During Pregnancy and Early Childhood: Practice Guidelines. Albany, NY: New York State Department of Health. Accessed on May 17, 2009