Dental Referral Form for Pregnant Women

SECTION A: PRENATAL PROVIDER TO COMPLETE (SEND TO DENTAL PROVIDER)

Patient Referred to: ______________________________ **Referral Date:** ____________

(Dentist Name | Practice)

Patient Information:

Name: ______________________________ ______________________________

(Last) *(First)*

DOB: ____ / ____ / ______ Estimated Delivery Date: ____ / ____ / ______

mm dd yyyy *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: *(Specify)*

REFERRING PRENATAL PROVIDER

Name: ______________________________ Signature: ______________________________

(Please Print)

Date: ______________________________ Phone #: (   )   -

Email: Fax #: (   )   -

SECTION B: DENTAL PROVIDER TO COMPLETE (RETURN TO PRENATAL PROVIDER)

Diagnosis:

Treatment Plan:

DENTAL PROVIDER

Name: ______________________________ Signature: ______________________________

(Please Print)

Date: Phone #: (   )   -

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Oral health care is covered by Medicaid for pregnant women in Maryland.
To find a dentist who accepts Medicaid, visit: **OralHealth4BetterHealth.com**

Provided By:

MARYLAND Department of Health

Permission is given to use this form, which can be found at: ***OralHealth4BetterHealth.com***