Dental Referral Form for Pregnant Patients

Referring Provider:		**Date of Referral:**	
Patient Name:		**DOB:**	
Due Date:		**Preferred Language**	
Medicaid or Insurance #		**Interpreter?**	Y | N
Patient Phone:			
List Current medications:			
Known allergies, precautions, relevant health history (asthma, high blood pressure, etc.)			

Reason for Referral (check all that apply):

☐ Routine Care
Estimated date of last exam: ☐> 6 months ☐ > One year ☐ > 5 years/never

☐ Potential caries, swollen or bleeding gums, other dental concern

☐ Patient experiencing oral or **dental pain today**, sign of infection or other urgent need

Other Notes:

Provider Signature	

DENTAL PROVIDER TO COMPLETE AND RETURN TO PRENATAL PROVIDER

Diagnosis:			
Treatment Plan:			
Dental Provider (print):		**Phone:**	
Signature		**Date:**	

Complete and return to us a _____
(FAX/email/office stamp)

Get support and learn more about how you can enhance your prenatal services at:
www.CavityFreeAtThree.org

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Department of Public Health & Environment