Community Smiles Dental
caring. serving. advocating.

OB/GYN Referral and Consent Form

Patient Name:_____ **DOB:**_____ **Date:**_____

Patient Phone #:_____ **Patient Address:**_____

Medicaid/Forwardhealth ID: _____

Weeks Gestation:_____ **Date 2nd Trimester begins:**_____

Estimated delivery date:_____ **Language spoken most often:**_____

Reason for Dental referral: (Please check all that apply)

- ❏ **Urgent** (I.E:Abscess tooth)
- ❏ **Routine Care** (I.E bleeding gums
- ❏ **This patient is cleared for routine evaluation and dental care, which may include but not limited To: (Please mark checkboxes & Inform patient)**

- ❏ Dental x rays as needed for diagnosis(Double Shielded abdominally & Double shield thyroid collar)
- ❏ Oral health examination
- ❏ Dental Prophylaxis
- ❏ Scaling & root planing
- ❏ Restoration of untreated caries(root canal therapy indicated)
- ❏ Extraction
- ❏ Standard local anesthetic(lidocaine with Epinephrine)***Note Lidocaine uses in dental is NOT available WITHOUT Epinephrine, Lidocaine HCL 2% with Epinephrine 1:100,000 is a risk factor 8.**
- ❏ Analgesics (if needed): Tylenol No.3 or Vicodin or Norco
- ❏ Antibiotics (If needed)

Current Medications:_____

Is this a high risk pregnancy Y or N (circle) If yes, why? :_____

Any Precautions? Specify(comments or instructions)_____

Significant Medical Conditions:_____

Known Allergies:_____

Prenatal care provider(Print Name):_____

Provider signature & date:_____

Please FAX completed form to Community Smiles Dental Attn: Clinical/Administrative Managers (262)522-2828

CSD Use: ONLY
DDS Signature & Date:_____ **Treatment OK up until date:**_____