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)
- ❏ **FOR ALL: This patient is cleared for routine evaluation and dental care, which may include but not limited to the following list: (Please mark this checkbox & 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 used 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 Manager**
**Waukesha Fax Number: (262)522-2828 OR Menomonee Falls Fax Number: (262)502-0508**

***CSD Use: ONLY***

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