MONTANA ORAL HEALTH PROGRAM — PublicHealth IN THE 406

Healthy Montana Mouths

Dental Referral – Pregnancy

Referral to Dentist	
Today's Date:	☐ Routine Referral ☐ Immediate Referral
Referring Practice:	Referring Provider:
Referring Provider Fax:	Referring Provider Phone:
Patient name:	Sex: ☐M ☐F DOB:
☐This patient is cleared for routine evaluation and dental care, which may include but not limited to: • Dental x-rays (with abdominal and neck shield) • Examination • Dental prophylaxis/ Scaling and root planing • Restoration of decay • Extraction • Standard local anesthesia • Analgesics (if needed): Aceetominophen • Antibiotics (if no known allergies):	Insurance: ☐ Medicaid ID#___________________ ☐ Other insurance_________________ ☐ Dental insurance_________________ ☐None/Self-pay
Significant medical conditions: ☐No ☐Yes (explain)	Any precautions: ☐No ☐Yes (explain)
Known allergies: ☐No ☐ Yes (please list)	Date of last fluoride varnish application: ______________ Fluoride supplement prescribed: ☐ Yes ☐ No
I consent to this medical provider sharing my information with the dentist/dental practice named below. I also consent to the dentist sharing my information with this medical provider.	Signature: ____ Date: ______________________________
Dentist/Dental Practice Name:	Phone: ______________________________ Fax: ______________________________
Dental Report to Medical Provider	
Date of appointment(s):	
Treatment provided: ☐ Oral hygiene instruction ☐Prophylaxis ☐Fluoride treatment	☐ Restorative care: ☐ Extractions: ☐ Other:
Summary:	Practice Name and address:
Dentist name:	Dentist signature: