



# OB Care Provider 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:

**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
- 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)

Is this an URGENT referral? If yes, why? \_\_\_\_\_

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: \_\_\_\_\_