DentaQuest

TennCare Adult Dental Program

DENTAL CARE REFERRAL FORM

FOR PREGNANT WOMEN TO RECEIVE ORAL HEALTH CARE

Referred to: ____ ______________________
Dental Provider Office Date

Patient Name: ______________________________ DOB: ___________ Date: _________

Expected Due Date: _________ Current Week of Gestation: ______ Allergies: _______________

☐ Pregnancy Precautions /Pertinent Medical History: ______________________________________
____

This patient is cleared to receive routine dental evaluation and care, including but not limited to:

- Oral health examination
- Dental prophylaxis
- Scaling and root planning
- Extraction
- Dental radiograph with abdominal and neck lead shield
- Local Anesthetic with epinephrine
- Root canal
- Restorations (amalgam or composite) fillings

This patient is cleared to receive the following medications: (Check all that apply)

Treatment may include any of the following:

☐ Acetaminophen with codeine for pain control

☐ Penicillin

☐ Clindamycin

☐ Erythromycin (Not estolate form)

☐ Alternative pain control medication:
(Specify)___________________________

☐ Amoxicillin

☐ Cephalosporins
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_______________________ _______________ _______________
Pre-natal Healthcare Provider Phone Email Address

__________________________________ __________________
Signature Prenatal Healthcare Provider Date

DENTAL PROVIDER REPORT

Diagnosis:____
____

Treatment Plan: _____________________________________ _______________

____

__________________________ _______ ___________________
Name Date Phone

Signature of Dentist: ______________________________ Email: _______________