OREGON ORAL HEALTH COALITION

Improving general health through oral health for all Oregonians

Oral Health Care Referral Form

Patient Information

Patient Name: _____

DOB: _____ Estimated Delivery Date: _____

Referral Information

Reason for Referral: ☐ Routine ☐ Bleeding Gums ☐ Pain ☐ Other: _____

☐ This patient is cleared for routine dental evaluation and care, which may include but not be limited to:

- Oral health examination
- Dental prophylaxis
- Treatment of diseased gum
- Dental x-rays
- Local anesthetic with epinephrine
- Root canal
- Restorations of untreated caries
- Dental extraction

Known Allergies: _____

Special Precautions: ☐ None ☐ Yes (specify) _____

Provider Information

Prenatal Care Provider: _____

Phone/ Pager: _____ Fax: _____

Signature: _____ Date: _____