

Date: [Date]

To: [Dentist Name / Dental Clinic Name]

From: [Obstetrician Name / Clinic Name]

Phone: [Phone Number]

Subject: Medical Clearance for Dental Treatment During Pregnancy

Patient Name: [Patient Full Name]

Date of Birth: [Patient DOB]

Current Gestational Age: [Number] weeks

Estimated Due Date: [Date]

Dear Doctor,

The above-named patient is currently under my care for pregnancy. At this time, the patient is medically cleared to undergo the following dental procedures:

- Routine dental cleaning and exams.
- Fillings, root canals, or extractions (using local anesthetic).
- Dental X-rays (with appropriate abdominal and thyroid shielding).

Recommendations and Precautions:

- **Anesthesia:** Local anesthetics with or without epinephrine (e.g., Lidocaine) are considered safe.
- **Medications:** For pain management, Acetaminophen is recommended. If antibiotics are required, Penicillin, Cephalosporins, or Erythromycin are generally preferred. Please avoid NSAIDs (e.g., Ibuprofen) and Tetracyclines.
- **Positioning:** To avoid supine hypotensive syndrome, please ensure the patient is slightly tilted to the left or has a small pillow under the right hip during procedures.

Patient Specific Restrictions: [None or specify any concerns]

If you have any questions regarding this clearance, please contact my office.

Sincerely,

[Signature of Obstetrician]

[Printed Name of Obstetrician]

[Medical License Number]