Patient Referral

INTRODUCING: _____

DATE: _____

Preferred Contact:

PHONE OR EMAIL: _____

Please call 951-769-1616 to schedule your patient's appointment or fax the completed form to 951-769-2327.

Referred by:

NAME: _____

ADDRESS: _____

PHONE #: _____ EMAIL: _____

Reasons for Referral:

This patient is being referred for evaluation of the following:

- ❑ Craniofacial Pain
  - ❑ Migraines
  - ❑ Tension headaches
  - ❑ Unexplained tooth/facial pain
  - ❑ Other _____
- ❑ Sleep Apnea
  - ❑ Appliance fabrication/Alteration
  - ❑ CPAP intolerant/non-compliant
- ❑ TMJ Disorder
  - ❑ Popping/clicking
  - ❑ Locked open/closed
  - ❑ Joint pain
  - ❑ Evaluation prior to major restorative/orthodontic care
  - ❑ Bruxism, Grinding teeth

Referring Providers Intentions:

I am sending:
- ❑ recent FMX, CBCT, MRI, etc.
- ❑ complete results of sleep study
- ❑ my plan for future restorative/major treatment

Please:
- ❑ Evaluate and call to discuss
- ❑ Evaluate and treat as necessary

j.sabo
TMJandSleepApnea.com
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