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Specialty Practice
Orofacial Pain and Dysfunctions

REFERRAL FORM

Dr._____ Telephone # _____

Email address: _____ Office address _____

would like to refer the following patient for an evaluation and recommendation:

Patient Name: _____ Phone # _____

Chief Concerns:

- ☐ Teeth grinding or jaw clenching
- ☐ Persistent toothaches
- ☐ Persistent tooth sensitivity
- ☐ Jaw soreness or pain
- ☐ Jaw clicking or popping
- ☐ Jaw locking
- ☐ Difficulty chewing
- ☐ Uncomfortable bite
- ☐ Limited oral opening
- ☐ Ringing in the ears
- ☐ Earache or stuffiness
- ☐ Lightheadedness or Dizziness
- ☐ Persistent sinus-like pain
- ☐ Abnormal orofacial movement
- ☐ Facial pain or numbness
- ☐ Facial muscle soreness
- ☐ Chronic head or neck aches
- ☐ Morning facial puffiness
- ☐ Intolerance to CPAP
- ☐ Snoring
- ☐ Gasping for air while asleep
- ☐ Oral herpes simplex
- ☐ Recurrent aphthous ulcer
- ☐ Oral facial herpes zoster
- ☐ Bad breath or dry mouth
- ☐ Burning mouth syndrome
- ☐ Oral mucosal ulceration

* Diplomate, American Boards of Orofacial Pain, Craniofacial Pain, Craniofacial Dental Sleep Medicine, and Dental Sleep Medicine.
** Diplomate, American Boards of Orofacial Pain and Dental Sleep Medicine.

Comments:_____