



Referral Form

Patient Information

Full Name: _____

Phone: _____

Date: ____ / ____ / ____

DOB: _____

Email: _____

Referring Provider

Provider Name: _____

Phone: _____

Office Name: _____

Email: _____

Reason for Referral

Evaluate for (Check all that apply)

- TMJ Disorders** (TMJ Pain, Limited Mouth Opening, Locked Jaw)
- Facial Pain** (Myofascial Pain, Neuralgia, Neuropathic Pain)
- Headaches** (Migraine, Tension-Type Headache, Trigeminal Autonomic Cephalgia)
- Orofacial Pain Management** (Trigger Point Injection, Botox Injection, Photobiomodulation)
- Sleep Disorders** (Home Sleep Test, Oral Sleep Appliance, Snoring)
- Other:** _____

Additional Notes
