SAN FRANCISCO CENTER FOR TMJ AND SLEEP APNEA

GREG D. LARSON, DDS, FAACP, AGDF

Treatment Referral/Consultation

Patient Information

Name: _____ DOB: _____

Address: _____

Home/Cell Phone: _____ Work Phone: _____

☐ Call Patient to Schedule?

Referring Physician: _____ Office Phone: _____

Location: _____ Fax: _____ Date of Referral: _____

Reason(s) for Referral:

TMJ

- ☐ Headaches
- ☐ Migraines
- ☐ Ear Pain, Stuffiness, or Ringing
- ☐ Facial Pain
- ☐ Limited Mouth Opening
- ☐ Pain or Stiffness in TM Joints
- ☐ Clicking, Popping or Grinding Sounds in TM Joints
- ☐ Locking Jaw (Open or Closed)
- ☐ Unexplained Tooth Pain
- ☐ Numbness in Fingers or Arms
- ☐ Dizziness

Sleep Apnea

- ☐ Obstructive Sleep Apnea Diagnosed / Suspected (Circle One)
  - ☐ Mild
  - ☐ Moderate
  - ☐ Severe
- ☐ CPAP Intolerant
- ☐ Snoring
- ☐ Upper Airway Resistance Syndrome (UARS)

Purpose of Consultation:

- ☐ Diagnose and treat patient as needed.
- ☐ Second Opinion. (Please indicate current diagnosis an/treatment.)

Additional information on symptoms or special instructions: _____

_____

Referring Physician's Signature _____ Date: _____

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