



SAN FRANCISCO CENTER FOR TMJ AND SLEEP APNEA

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Treatment Referral/Consultation

Patient Information

Name: _____ DOB: _____

Address: _____

Home/Cell Phone: _____ Email: _____

Call Patient to Schedule?

Referring Physician: _____ Office Phone: _____

Location: _____ Fax: _____ Date of Referral: _____

Reason(s) for Referral:

TMJ

- | | |
|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Clicking, Popping or Grinding Sounds in TM Joints |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Locking Jaw (Open or Closed) |
| <input type="checkbox"/> Ear Pain, Stuffiness, or Ringing | <input type="checkbox"/> Unexplained Tooth Pain |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Numbness in Fingers or Arms |
| <input type="checkbox"/> Limited Mouth Opening | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Pain or Stiffness in TM Joints | |

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: _____