



# SAN FRANCISCO CENTER FOR TMJ AND SLEEP APNEA

AMIN SAMADIAN, DMD, DDS, MBA  
GREG D. LARSON, DDS, DABCP, DABDSM, DABCDMS

## 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: \_\_\_\_\_