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Diagnosis and Treatment of Temporomandibular Disorders/Orofacial Pain, Sleep Breathing Disorders & Oral Diseases

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Phone: (780)428-6836

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Email: tmdofpteam@gmail.com

Website: www.tmdclinic.ca

Date: _____

Patient: _____

DOB (MM/DD/YY): _____ Parent name: (If patient is under 18) _____

****If patient is under 18, parent must accompany patient****

Phone: _____ email: _____

Address: _____

City/Province: _____ Postal code: _____

Referred for: TMD/Orofacial Pain Sleep Apnea/Snoring Oral Lesion/Biopsy

Relevant information: _____

Panoramic Radiograph: (Less than three years old)†

With Patient Mailed Emailed None

**** If Pan is not available, we would prefer to take our own. Thank you ****

Is this referral as a result of:

MVA WCB

Referring Doctor: _____

Address: _____ email: _____

Phone number: _____ Fax number: _____

Thank you for this referral