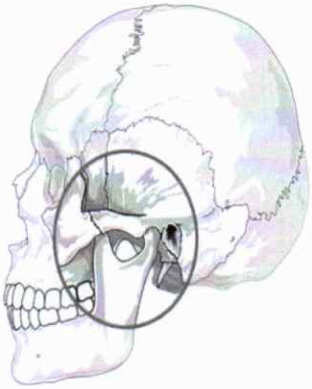

Diagnosis and Treatment of Temporomandibular Disorders/Orofacial Pain, Sleep Breathing Disorders & Oral Diseases

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Phone: (780)428-6836
Fax: (780)426-3304
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