HEALTH & BEAUTY DENTISTRY

BY DR. SHAUNA PALMER

Referral Form for TMD/TMJ//OSA and/or SMART

Patient's Name

First name: ____ Last name: ____

Birth date: (mm/dd/yyyy) ____ Gender: ◯ F ◯ M ◯ Other

Address:

Street: ____ City: ____ PC: ____ Province: ____

E-mail: ____ Phone: ____ Work phone: ____

Symptoms

- [ ] Headache / Migraine
- [ ] Facial pain (Nonspecific)
- [ ] Tender, Sensitive Teeth (Percussion)
- [ ] Cervical pain
- [ ] Difficulty chewing
- [ ] Postural problems
- [ ] Tingling of fingertips
- [ ] Thermal sensitivity (Hot and Cold)
- [ ] Trigeminal Neuralgia
- [ ] Bell's Palsy
- [ ] Nervousness / Insomnia

Tender, Senitive Teeth (Percussion)

- [ ] TMJ Pain
- [ ] TMJ Noise
- [ ] Limited Opening
- [ ] Vertigo (Dizziness)
- [ ] Tinnitus (Ringing in the ears)
- [ ] Ear Congestion
- [ ] Loose Teeth
- [ ] Clenching / Bruxing
- [ ] Difficulty Swallowing
- [ ] Difficulty Sleeping
- [ ] Snoring or stopping breathing at night
- [ ] Fatigue
- [ ] Obstructive Sleep Apnea AHI
- [ ] RHI
- [ ] CPAP Intolerant

Reason for referral: ____

Health Practitioner's Name:

First name: ____ Last name: ____

Phone: ____ Date: (mm/dd/yyyy) ____

Health Practitioner's Signature: ____

Fax Referral to: 778 - 754 - 8102 **Email to: reception@healthandbeauty.dentist**