HEALTH & BEAUTY DENTISTRY

BY DR. SHAUNA PALMER

# Referral Form for Temporal Mandibular Disorder

## Patient's Information

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) | ☐ |
| TMJ Pain | ☐ | Tender, Sensitive Teeth (Percussion) | ☐ |
| TMJ Noise | ☐ | Difficulty chewing | ☐ |
| Limited opening | ☐ | Cervical pain / Shoulder pain | ☐ |
| Vertigo (Dizziness) | ☐ | Postural problems | ☐ |
| Tinnitus (Ringing in the ears) | ☐ | Tingling of fingertips | ☐ |
| Ear congestion | ☐ | Thermal sensitivity (Hot and Cold) | ☐ |
| Loose teeth | ☐ | Trigeminal Neuralgia | ☐ |
| Clenching / Bruxing | ☐ | Bell's Palsy | ☐ |
| Difficulty swallowing | ☐ | Nervousness / Insomnia | ☐ |

**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**