# REFERRAL FORM

**TMD/Orofacial Pain Clinic**

**Dr. Vandana Singh, Oral Medicine**
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*FAX ONLY COMPLETED FORMS TO **780-306-5757**.*

| | | | |
|---|---|---|---|
| **PATIENT INFO** | **Name:** | | **Gender:** ☐Male ☐Female ☐Other |
| | **Address** (including city & postal code): | | |
| | **Best Contact Phone number:** | | |
| | **AHC #:** | **D.O.B:** | |
| **REFERRING PHYSICIAN** | **Name:** | **PRAC-ID:** | **Specialty:** |
| | **Address (including city & postal code):** | | |
| | **Phone:** | **Fax:** | **Email:** |
| **FAMILY PHYSICIAN**<br><br>☐ **NO FAMILY PHYSICIAN** | **Name:** | **PRAC-ID:** | |
| | **Address** (including city & postal code): | | |
| | **Phone:** | **Fax:** | **Email:** |

| **REFERRAL INFORMATION** | | |
|---|---|---|
| REASON FOR REFERRAL | ☐ *Oral mucosal lesions*<br>☐ *TMJD/Sleep medicine*<br>☐ *Orofacial pain*<br>☐ *Burning mouth*<br>☐ *Neuromodulators*<br>☐ *Headache/migraine* | Other: |
| PATIENT MEDICAL HISTORY<br><br>*If known: past medical history, surgical history, medications, allergies, family history, current medications* | | |

**RADIOGRAPHS OR CLINICAL PHOTOS**: ☐PAN ☐Periapical ☐CBCT

**REFERRING MD SIGNATURE:** _____ **DATE:** _____