REFERRAL FOR TMJ/TMD CONSULTATION

Patient Name_____ Date: _____

PHN_____ Date of Birth_____ Pt Email_____

Pt Phone_____ Pt Cell_____ Pt other_____

Address_____City_____ Postal Code_____

Family Physician_____ Phone_____ Fax_____

Please Fax or Email to:

604-587-5336 (Surrey) infosurrey@sleepbetterlivebetter.ca

604-987-5336 (North Van) info@sleepbetterlivebetter.ca

Please indicate if URGENT (Acute Lock)

Patient symptoms:

___ Headache ___ Migraine ___ Grinding ___ Clenching ___ Jaw/Face Pain

___ Ear congestion/Pain___ Neck Stiffness/Pain

Other _____

Referring Office/Clinician information: Please provide company/ therapist information

_____

Name of referring clinician

_____

Signature of referring clinician

office stamp

Dr. Sharnell Muir
Sleep Better Live Better
212-700 Marine Drive, North Vancouver, BC V7M 1H3
Phone: 604.987.5337 Fax: 604.987.5336 info@sleepbetterlivebetter.ca www.sleepbetterlivebetter.ca
503-13737 96 Avenue, Surrey, BC V3V 0C6
Phone: 604.587.5337 Fax: 604.587.5336 infosurrey@sleepbetterlivebetter.ca www.sleepbetterlivebetter.ca