



## 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](mailto:infosurrey@sleepbetterlivebetter.ca)**  
**604-987-5336 (North Van) [info@sleepbetterlivebetter.ca](mailto: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*  
[www.sleepbetterlivebetter.ca](http://www.sleepbetterlivebetter.ca)