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

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