



**Southland Dental Choice**  
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DMD, BSc

## Orofacial Pain & TMD Referral Form

### Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Email: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

### Patient Symptoms

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> TMJ Pain                            | <input type="checkbox"/> Jaw Popping and/or Clicking               | <input type="checkbox"/> Jaw Locked                           |
| <input type="checkbox"/> Headaches                           | <input type="checkbox"/> Jaw Movement Disorder                     | <input type="checkbox"/> Open <input type="checkbox"/> Closed |
| <input type="checkbox"/> Neck, Shoulder, Back or Facial Pain | <input type="checkbox"/> Ringing, Stiffness, or Pain in the Ear(s) | <input type="checkbox"/> History of                           |
| <input type="checkbox"/> Grinding and/or Clicking            |  | <input type="checkbox"/> TMD Treatments                       |
| <input type="checkbox"/> Other, please explain: _____        |  | <input type="checkbox"/> Trauma to the Head and Neck Region   |

*\*Please include copies of all relevant records and documentation (i.e Sleep Studies, X-rays)*

### Chief Complaint

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### Referring Provider

Referring Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Additional Comments: \_\_\_\_\_