DENTIST / TMJ REFERRAL FORM

15170 127 St NW #203, Edmonton, AB T6V 0C5 | P: (587) 416-4922
Clinic Owner: Mohammed Hamdon

Date: _____

Patient Name: _____

Date of Birth: _____

Patient Phone / Email: _____

Referring Dentist / Clinic: _____

Diagnosis / Reason for Referral: _____

TMJ / OROFACIAL SYMPTOMS & FINDINGS

- ☐ Jaw / TMJ pain
- ☐ Jaw clicking or popping
- ☐ Jaw locking / catching
- ☐ Limited or painful mouth opening
- ☐ Pain with chewing / biting
- ☐ Clenching or bruxism
- ☐ Facial / masseter pain
- ☐ Temple / temporalis pain
- ☐ Headaches
- ☐ Neck or upper cervical pain
- ☐ Ear symptoms / tinnitus / fullness
- ☐ Numbness or tingling
- ☐ Post dental procedure / prolonged opening
- ☐ Other: _____

REQUESTED PHYSIOTHERAPY

- ☐ TMJ / TMD assessment and treatment
- ☐ Jaw mobility / muscle rehabilitation
- ☐ Cervical / postural assessment
- ☐ Other: _____

Clinical Notes / Relevant Dental Findings:

_____

_____

_____

Referring Dentist / Health Care Provider: _____

Signature: _____

Date: _____

Phone / Fax: _____

Please provide any relevant imaging, dental findings, precautions, or treatment considerations with this referral.