TMJ & Sleep Therapy Centre
VANCOUVER

REFERRAL FORM

☐ Dr. Lara Perel-Panar, DDS ☐ _____

PATIENT INFORMATION

Patient name

Age Birth date (YYYY/MM/DD) Gender

Phone Email

Parent/Guardian name (if applicable)

Notes

SYMPTOMS SCREENING

- ☐ Jaw pain
- ☐ Jaw clicking
- ☐ Facial pain
- ☐ Headache
- ☐ Migraines
- ☐ Tooth grinding
- ☐ Pain on chewing
- ☐ Acute locked jaw
- ☐ Limited opening
- ☐ Sleep disordered breathing
- ☐ Snoring
- ☐ CPAP intolerant
- ☐ Other .....

REFERRING PRACTITIONER

Through comprehensive diagnostics, we determine the cause of pain and dysfunction. We provide non-surgical therapeutic care for rehabilitation and improved quality of life.

Referred by

Phone Fax

Date

Signature

☐ Exam ☐ 2nd Opinion ☐ Send report ☐ Call requested

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