ALVARO ORDONEZ, DDS

TMJ Referral Form

Dr. _____

Would like to introduce:

Name: _____

Address: _____

_____

Phone: _____

Chief concerns:

- ☐ Tmj Pain
- ☐ Refractory toothaches
- ☐ Neck aches
- ☐ Facial Pain
- ☐ Limited Opening
- ☐ Clicking of Joints
- ☐ Muscles Soreness
- ☐ Uncomfortable Bite
- ☐ Snore & Sleep Apnea
- ☐ Emergency visit
- ☐ Others: _____

Please call to arrange an examination to evaluate this problem _____

_____

I am planning:

1. _____
2. _____
3. _____
4. _____
5. _____

I would like to request the following:

- ☐ Only clinical evaluation at this time
- ☐ Electromyography (EMG) (Muscle activities testing)
- ☐ Use your discretion in diagnosing this patient
- ☐ Diagnosis and treatment
- ☐ CBCT

I would like to request the following:

- ☐ A telephone call
- ☐ A report
- ☐ A report and copy of record

Requesting doctor's Name : _____

Address: _____

_____

Phone: _____

Best time to call: _____

- ☐ Please perform any pertinent dental treatment in your practice.
- ☐ Please send patient back to our practice for any dental related treatment

_____

Requesting doctor's signature

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