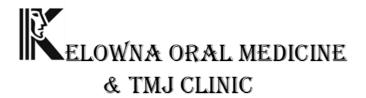


REFERRAL FORM Fax:1-888-463-0167 Tel: 236-301-5197 info@kelownaomtmj.ca

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PATIE	ENT INFORMATION		REFERRING	CLINICIAN	
Full N	lame		Full Name		
PHN			CDA/MSP No. (if available)		
	(mm/dd/yyyy)		Office Name		
Addr	ess		Address		
City		City			
Province		Province			
PC		PC			
Home		Phone			
Cell		Fax			
Email		Email			
INICII	RANCE				
			Secondary		
Primary Name of Insured		Name of Insured			
		Employer			
Employer Plan Name		Plan Name			
Policy No.		Policy No.			
ID No.		ID No.			
DOB		DOB			
			202		
REA	SON FOR THE REFERRAL	LETTER A	ATTACHED		
	Oral mucosal lesions			Sleep medicine	
	Oral mucosar lesions			Sieep medicine	
	Temporomandibular joint disorders			Neuromodulator injection	
	Orofacial pain			General Oral Pathology	
	Burning mouth			Headache/Migraine/Neuropathic pain	



Comment:				
URGENT/EMERGENCY		Yes		
MEDICAL/SURGICAL HISTORY			Letter Attached	I
ALLERGIES/MEDICATIONS			Letter Attached	I
RADIOGRAPHS	None		by Mail	by Email

RADIOGRAPHS OR CLINICAL PHOTOS: • PAN • Periapical

We will contact the patient directly for an appointment.

CBCT