**REFERRAL FORM**

**Fax:1-888-463-0167**

**Tel: 236-301-5197**

**info@kelownaomtmj.ca**

Date:

**PATIENT INFORMATION**  **REFERRING CLINICIAN**

Full Name Full Name

PHN CDA/MSP No. (if available)

(mm/dd/yyyy)

DOB Office Name

Address Address

City City

Province Province

PC PC

Home Phone

Cell Fax

Email Email

**INSURANCE**

*Primary*  *Secondary*

Name of Insured Name of Insured

Employer Employer

Plan Name Plan Name

Policy No. Policy No.

ID No. ID No.

DOB DOB

**REASON FOR THE REFERRAL** LETTER ATTACHED

 Oral mucosal lesions  Sleep medicine

 Temporomandibular joint disorders  Neuromodulator injection

 Orofacial pain  General Oral Pathology

 Burning mouth  Headache/Migraine/Neuropathic pain

**Comment:**

**URGENT/EMERGENCY** Yes NO

**MEDICAL/SURGICAL HISTORY** Letter Attached

**ALLERGIES/MEDICATIONS** Letter Attached

**RADIOGRAPHS** None by Mail by Email

**RADIOGRAPHS OR CLINICAL PHOTOS:** PAN Periapical CBCT

We will contact the patient directly for an appointment.