PATIENT REFERRAL FORM

Melbourne
TMJ & Facial Pain
Centre

Date.....

Patient Details

Name..... Date of Birth.....

Address.....

Phone Number.....

Reason for Referral

- ☐ Sleep assessment (snoring, sleep apnoea,poor sleep)
- ☐ Dental TMJ assessment
- ☐ Teeth Grinding assessment
- ☐ Other.....

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Investigations

Please send copies of relevant investigation results (eg. sleep studies, xrays)

Referrer Details

Name.....

Medical / Dental / Other .....

Address for correspondence.....

Phone Number.....

PRACTICE STAMP

Please fax referral to 9824 8867 or
email info@melbournetmjcentre.com.au

Melbourne TMJ & Facial Pain Centre
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e: info@melbournetmjcentre.com.au **w:** melbournetmjcentre.com.au