



Melbourne
TMJ & Facial Pain
Centre

PATIENT REFERRAL FORM

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.....

Investigations

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

Referrer Details

Name.....

Medical / Dental / Other

Address for correspondence.....

Phone Number.....



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

Melbourne TMJ & Facial Pain Centre

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