



REFERRAL FORM

TMD/Orofacial Pain Clinic

Dr. Vandana Singh, Oral Medicine
 Canadian Cancer Care
 Edmonton Comprehensive Care & Family Medicine
 110, 6925 Gateway Blvd NW
 Edmonton, AB T6H 2J1
 P: 780-306-5656 F: 780-306-5757

FAX ONLY COMPLETED FORMS TO 780-306-5757.

PATIENT INFO	Name:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other	
	Address:		City & Province:	Postal Code:
	Best Contact Phone Number:			
	Alberta Health Care:		Date of Birth:	
REFERRING PHYSICIAN INFO	Name:		Practitioner ID:	Specialty:
	Address:		City & Province:	Postal Code:
	Phone:	Fax:	Email:	
FAMILY PHYSICIAN INFO	Name:		Practitioner ID:	
	Address:		City & Province:	Postal Code:
	Phone:	Fax:	Email:	

REFERRAL INFORMATION	
REASON FOR REFERRAL	<input type="checkbox"/> Oral mucosal lesions <input type="checkbox"/> Burning mouth Other: <input type="checkbox"/> Temporomandibular joint disorders (TMJD)/Sleep medicine <input type="checkbox"/> Neuromodulators <input type="checkbox"/> Orofacial pain <input type="checkbox"/> Headache/migraine
PATIENT MEDICAL HISTORY	
<i>If known: past medical history, surgical history, medications, allergies, family history, current medication</i>	

Although TMJ is not covered by Alberta Health Care, treatment is often covered by other health care plans.

RADIOGRAPHS OR CLINICAL PHOTOS: PAN Periapical CBCT

REFERRING MD SIGNATURE: _____ DATE: _____