REFERRAL FORM

TMD/Orofacial Pain Clinic

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

*FAX ONLY COMPLETED FORMS TO **780-306-5757**.*

PATIENT INFO	Name:		Gender: ☐Male ☐Female ☐Other
	Address:	City & Province:	Postal Code:
	Best Contact Phone Number:		
	Alberta Health Care:		Date of Birth:
REFERRING PHYSICAN INFO	Name:	**Practitioner ID:** a pracid is NOT the same as a Unique # and can be obtained by calling 780-422-1522**	Specialty:
	Address:	City & Province:	Postal Code:
	Phone:	Fax:	Email:
FAMILY PHYSICIAN INFO	Name:		Practitioner ID:
	Address:	City & Province:	Postal Code:
	Phone:	Fax:	Email:

REFERRAL INFORAMTION			
REASON FOR REFERRAL	☐Oral mucosal lesions ☐Temporomandibular joint disorders (TMJD)/Sleep medicine ☐Orofacial pain	☐Burning mouth ☐Neuromodulators ☐Headache/migraine	Other:
PATIENT MEDICAL HISTORY *If known: past medical history, surgical history, medications, allergies, family history, current medication*			

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: ____________________