Referral Form

SCREENING FORM

For Patients with Head, Neck and Facial Pain & Sleep Disordered Breathing/Apnea

- ❑ Primary headaches or migraines
- ❑ Snoring/Sleep Apnea
- ❑ Disturbed, restless sleeping
- ❑ CPAP Intolerance
- ❑ Daytime drowsiness
- ❑ ADD
- ❑ Earaches, stuffiness or ringing
- ❑ Neck, shoulder, back pain or stiffness
- ❑ Dizziness
- ❑ Pain or soreness in TM joints
- ❑ Limited mouth opening
- ❑ Locking jaw (opened or closed)
- ❑ Facial or undiagnosed teeth pain
- ❑ Difficulty swallowing

When your patients experience one or more of these symptoms, they should have a thorough evaluation by a dentist trained in TM and Sleep. We will be happy to assist you in diagnosis and treatment for possible Craniomandibular, Temporomandibular or Sleep Disordered Breathing/Apnea.

Patient Information

Name:

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Address:

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Phone:

____

Email:

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Date:__________Fax:______________

Referring Doctor & Phone Number:

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__Exam__2nd Opinion__Send Report__Call Me

TMJ & Sleep Therapy Centre of North Texas

ShabKrish, DDS, MS

Diplomate

American Board of Craniofacial Pain

American Board of Craniofacial Dental Sleep Medicine

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Please fax referral to TMJ & Sleep Therapy Centre and give a copy to the patient