PAIN AND SLEEP
Therapy Center

Treatment Referral / Consultation

Greg D. Larson, DDS, DABCP, DABDSM, DABCDSM

Patient Name: _____ **DOB:** _____

Address: _____

Patient Phone #: _____ **Email:** _____

Referring Doctor: _____ **Office Phone:** _____

Location: _____ **Fax:** _____ **Date of Referral:** _____

Reason(s) for Referral:

TMJ

- Headaches
- Migraines
- Ear Pain, Stuffiness or Ringing
- Facial Pain
- Limited Mouth Opening
- Pain or Stiffness in TM Joints
- Clicking, Popping or Grinding Sounds in TM Joints
- Locking Jaw (Open or Closed)
- Unexplained Tooth Pain
- Numbness in Fingers or Arms
- Dizziness

Sleep Apnea

- Obstructive Sleep Apnea Diagnosed/ Suspected (Circle One)
  - Mild
  - Moderate
  - Severe
- CPAP Intolerant
- Snoring
- Upper Airway Resistance Syndrome (UARS)

Purpose of Consultation:

Diagnose and treat patient as needed.

Second Opinion (Please indicate current diagnosis/ treatment)

Additional information on symptoms or special instructions:

_____

_____

Referring Doctor's Signature: _____ **Date:** _____

Thank You!

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