

## Dental / Facial Pain Referral Form

18 YEARS OF AGE OR OLDER

### Dentist/Dental Office Information:

(Name, Telephone, Fax number, Address, Email)

### Patient Information:

(Name, Date of Birth, Health Card, Telephone & Address)

Please select the preferred clinic for your patient:

Toronto  Mississauga  Brampton  Scarborough  Oshawa  London  Ottawa  Hamilton

Primary Dental complaint:  Temporomandibular Joint Pain (TMJ)

Headache/ Migraine Pain

Other: \_\_\_\_\_

Treatment provided: \_\_\_\_\_

Mechanical concern addressed? Y  N

Duration of pain complaint: \_\_\_\_\_

Using Night Guard? Y  N

Is the patient on blood thinners? Y  N

Has the patient tried Botox? Y  N

Patient's Family Doctor Name: \_\_\_\_\_

Email: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

- Patient advised to make Family Doctor aware of referral to NeuPath, Centre for Pain & Spine for Dental/Facial Pain. Consultation reports will be sent to both the referring dentist and the family doctor.
- Patient advised that referral to NeuPath, Centre for Pain & Spine is only for interventional treatment of their dental pain. If assessment of any other pain is required, a referral from the Family doctor will be required.

**Dentist Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_