NeuPath
Centre for Pain & Spine

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:

☐ 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:** _____