Sleep BetterColumbus

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SLEEP / TMJ REFERRAL

Patient Name: DOB:

Phone: Email:

Chief Complaint:

Please check off possible sleep related signs and symptoms

- ☐ Snoring
- ☐ Morning Headaches
- ☐ Sleep Apnea, diagnosed
- ☐ Daytime Sleepiness
- ☐ Intolerance to CPAP
- ☐ Sleep bruxism

Please check off possible sleep related signs and symptoms

- ☐ Headaches
- ☐ Neckaches
- ☐ Dizziness
- ☐ Ear Pain
- ☐ Fainting
- ☐ Sleep bruxism
- ☐ Limited jaw opening
- ☐ Clenching
- ☐ Clicking or locking jaw
- ☐ Chronic Fatigue
- ☐ Tinnitus
- ☐ Shoulder or back pain

HEALTHCARE PROVIDER INFORMATION:

Physician Name: NPI:

Address:

City: State: Zip:

Phone: Fax:

Provider Signature: Date:

PLEASE FAX TO: (888) 390-0424

THANK YOU!