PAIN & WELLNESS CENTRE

2301 Major Mackenzie Dr. W., #101
Vaughan On L6A 3Z3
Tel: 1-800-597-5733
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Jaw & Facial Pain Program: Referral Form

Patient Information

Name: _____

Phone Number: _____

Referring Practitioner Information

Name: _____

Phone Number: _____

Fax Number: _____

Address: _____

Brief Description of the Patient's Pain: (Check All That Apply)

	Right Jaw Pain
	Left Jaw Pain
	Bilateral Jaw Pain
	Altered Mandibular Gait Mechanics
	Nocturnal Grinding/Clenching

	Painful Jaw Clicking
	Other (Please Describe):

I have informed my patient about this referral: Yes/No

Please send any additional documentation you feel is necessary.

NOTE: We will provide referring practitioners with consultation and discharge notes for their records.

Thank you for your referral. Your patient will be called and scheduled within 2 weeks