CENTENNIAL

THE TMJ & HEADACHE INSTITUTE OF COLORADO

WESTMINSTER

MEDICAL PROVIDER REFERRAL FORM

Referring Provider: _____ Date: _____

Patient Name: _____ Phone: _____

☑ The patient has given consent for the transfer of personal information to The TMJ & Headache Institute of Colorado

Additional Comments:

- ☑ Evaluate and Treat
- ☑ TMJ Pain Jaw
- ☑ Clicking/Popping
- ☑ Jaw Locking
- ☑ Limited Jaw
- ☑ Opening
- ☑ Headaches
- ☐ Clenching/Bruxism
- ☐ Tinnitus
- ☐ Trismus
- ☐ Post-Surgical
- ☐ Ear Fullness
- ☐ Hearing Loss
- ☐ Tooth
- ☐ Pain/Sensitivity
- ☐ Neck/Shoulder/Back
- ☐ Pain Facial Pain
- ☐ Whiplash
- ☐ Limited/Painful Neck Motion

You may email this PDF form PatientSuccess@TMJInstituteColorado.com along with any relevant notes.

Thank you for the opportunity to assist in the care of your patients!
Be assured quality care is our highest priority.