Email completed form to
drhaddad@michigantmjandsleep.com
or fax to (248)267-9711 att: Dr. Haddad
Call Our Office: (248) 825-8277

Michigan Center
for TMJ & Sleep Wellness

REFERRAL FORM

PATIENT NAME: PATIENT _____

PHONE: EMAIL: _____ CELL: _____

REFERRING DOCTOR: _____

_____

REASON FOR REFERRAL:

- ☐ Evaluation for TMJ Disorder
- ☐ Evaluation for Sleep Disorder
- ☐ Both
- ☐ Fabrication of sleep appliance due to snoring or CPAP intolerance

TMJ SYMPTOMS:

- ☐ Headaches
- ☐ Migraines
- ☐ Jaw Pain
- ☐ Neck Pain
- ☐ Ear pain
- ☐ Subjective hearing loss
- ☐ Ear Congestion or blockage
- ☐ Tinnitus (ringing in ears)
- ☐ Vertigo (Dizziness)
- ☐ Clicking or popping in TMJ
- ☐ Sinus pain pressure

SLEEP SYMPTOMS:

- ☐ Snoring
- ☐ Constantly tired
- ☐ Morning headaches
- ☐ Diagnosed sleep apnea
- ☐ Reported gasping at night *(possible sleep apnea)*
- ☐ CPAP intolerant

Has patient had a sleep study? ☐ YES ☐ NO

OTHER INFORMATION OR REQUESTS:

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