TMJ & Sleep Therapy
Dr. Lisa A. DiGioia
Breathe • Sleep • Heal • Live

Today's date: _____

PATIENT INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ Phone number: _____

Address: _____

City: _____ Province: _____ Postal code: _____

Email: _____

REFERRING OFFICE

Office Name: _____ Doctor Name: _____

Email: _____ Phone number: _____

PATIENT SCREENING/SYMPTOMS

- ◯ Headaches or migraines
- ◯ Snoring
- ◯ Sleep Apnea
- ◯ Disturbed or restless sleep
- ◯ CPAP Intolerance
- ◯ Daytime drowsiness
- ◯ Earaches, stuffiness or ringing
- ◯ Neck, shoulder, back pain, stiffness
- ◯ Dizziness
- ◯ Pain or soreness in TM joints
- ◯ Limited mouth opening
- ◯ Jaw locking (opened or closed)
- ◯ Facial or undiagnosed teeth pain
- ◯ Difficulty swallowing

Has the patient had a sleep study done? If so, when and at which facility?

_____

_____

*Please email completed referral forms to **info@tmjsleeptherapy.ca** or fax to **519-733-2797.***

p: 519-733-8888 **w: Tmjsleeptherapy.ca**