The Center for TMJ and Sleep Apnea

Treatment Referral / Consultation

Greg D. Larson, DDS, DABCP, DABDSM, DABCDSM

Patient Name: ______________________________ **DOB:** ______________

Address: ____

Patient Phone #: ______________ **Email:** ______________________

Referring Doctor: ______________________ **Office Phone:** ______________

Location: ______________ **Fax:** ______________ **Date of Referral:** ______________

Reason(s) for Referral:

TMJ

- ☐ Headaches
- ☐ Migraines
- ☐ Ear Pain, Stuffiness or Ringing
- ☐ Facial Pain
- ☐ Limited Mouth Opening
- ☐ Pain or Stiffness in TM Joints
- ☐ Clicking, Popping or Grinding Sounds in TM Joints
- ☐ Locking Jaw (Open or Closed)
- ☐ Unexplained Tooth Pain
- ☐ Numbness in Fingers or Arms
- ☐ Dizziness

Sleep Apnea

- ☐ Obstructive Sleep Apnea Diagnosed / Suspected (Circle One)
  - ☐ Mild
  - ☐ Moderate
  - ☐ Severe
- ☐ CPAP Intolerant
- ☐ Snoring
- ☐ Upper Airway Resistance Syndrome (UARS)

Purpose of Consultation:

☐ Diagnose and treat patient as needed.

☐ Second Opinion (Please indicate current diagnosis / treatment)

Additional information on symptoms or special instructions:

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Referring Doctor's Signature: ______________________________ **Date:** ______________

Thank You!

- **Charlotte Location: 6235 Blakeney Park Drive Suite 101 Charlotte, NC 28277**
- **Concord Location: 1000 Copperfield Blvd. Suite 154 Concord, NC 28025**

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