MEDICAL REFERRAL

Patient Information	
Last Name	
First Name	
Date of Birth	
Male/Female	
Address	
Guardian	
Relationship with Patient	
Home Phone	
Mobile	
Email	

Growth / Orthodontics	
Mouth Breathing	
Open Bite	
Retruded Mandible	
Retruded Maxilla	
“Buck teeth”	
Dental Crowding	
Dental Spacing	
Sleep Problems	
Focus Problems	
Behaviour Problems	

In the case of a complex Medical History please attach a separate detailed History and/or Medications List

It may also be advantageous to attach a “Lamberg Questionnaire”.

Sleep and Respiration	
Snoring	
Difficulty commencing sleep	
Night-time awakenings	
Excessive sleep movements	
Unrefreshed sleep	
Daytime Sleepiness	
Heartburn / Reflux	
Known OSA	
Using CPAP	
Using Oral Appliance	
Bruxism	
Morning Headaches	
Blood Pressure	
Other CV Problems	
Respiratory Problems	
Neurological Problems	
Depression / Anxiety	
Poor Concentration	

TMD and Orofacial Pain	
TMJ Pain	
TMJ Noises	
Jaw Locking (open/closed)	
Bruxism	
Sore or loose teeth	
Headaches	
Facial Pain	
Neck/Shoulder Pain	
Difficulty Swallowing	
Tinnitus	

MOUNTAINS TMJ & DENTAL SLEEP MEDICINE

Dr Trevor J Baret
BDS; PGDipClinOrth

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www.mdsm.com.au

REFERRING DOCTOR

Doctor –

Clinic –

Address –

Phone –

Email –

Provider # –

Signature –

Date –