NeuPath
Centre for Pain & Spine

Dental / Facial Pain Referral Form

18 YEARS OF AGE OR OLDER

Dentist/Dental Office Information:
(Name, Telephone, Fax number, Address)

Patient Information:
(Name, Date of Birth, Health Card, Telephone & Address)

Please select the preferred clinic for your patient:

☐Toronto ☐Mississauga ☐Brampton ☐Scarborough ☐Oakville ☐Oshawa ☐London ☐Ottawa ☐ Hamilton

Primary Dental complaint: ☐ Temporomandibular Joint Pain (TMJ)

☐ Headache/ Migraine Pain

☐ Other:_____

Treatment provided:_____

Mechanical concern addressed? Y ☐ N ☐

Duration of pain complaint: _____

Using Night Guard? Y☐N ☐

Is the patient on blood thinners? Y☐N ☐

Has the patient tried Botox? Y ☐ N ☐

Patient's Family Doctor Name: _____

Address: _____

Phone Number:_____Fax Number:_____

☐ Patient advised to make Family Doctor aware of referral to Centres for Pain Management for Dental/Facial Pain. Consultation reports will be sent to both the referring dentist and the familydoctor.

☐ Patient advised that referral to Centres for Pain Management is only for interventional treatment of their dental pain. If assessment of any other pain is required, a referral from the Family doctor will be required.

Dentist Signature:_____ **Date:** _____

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FAX REFERRALS TO 1-877-883-3301 CALL TOLL FREE 1-800-265-3429 ext 1022

neupath.com