Silver Sleep Dentistry

**Dr Simi Silver, DDS D.ABDSM**
**www.tmjsleepcentre.ca**
**613.829.5921**

***Provider making the referral***

_____*Name*

_____*Email*

## PATIENT REFERRAL

**Patient Name**: _____

Date of Birth: _____ Phone: _____

Parent/Guardian Name: _____

Email: _____

**PATIENT** **Primary concern; *in their own words:***

_____

_____

## REASON FOR REFERRAL

- ☐ Infant tongue & lip tie
- ☐ Oral habits, thumbsucking
- ☐ Mouth breathing
- ☐ Tongue and ties
- ☐ CPAP issues
- ☐ Snoring
- ☐ TMJ and orofacial pain
- ☐ Bruxism, Teeth Grinding
- ☐ Crossbite
- ☐ Headaches
- ☐ Large tongue
- ☐ Insomnia
- ☐ Open Bite
- ☐ Nasal Congestion

**RESTORATIVE** Y / N All pre-orthodontic restorative treatment is complete

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