Referral Form

Date : ____________________
Referring Doctor : ____________________
Address : ____________________
____
Fax# : ____________________
Phone# : ____________________

Patient: ____________________
D.O.B.: ____________________
Address: ____________________
____
____
Phone#: ____________________

Evaluation and treatment of TMJ disorder and/or Orofacial pain. Check all answers that apply.

ONSET :	● Chronic	● Acute	● Traumatic	
DURATION :	● ___days	● ___weeks	● ___years	
SITE :	● Frontal	● Temporal	● Parietal	● Cervical
	● Occipital	● Vertex	● Zygomatic	● Ear
	● Periorbital	● Nasal	● Facial	● Oral
	● Mandibular	● Dental	● TMJ	
MANDIBULAR LOCKING :	● No	● Yes	● Open	● Closed
DEGREE OF PAIN :	● Mild	● Moderate	● Severe	

Obstructive Sleep Apnea

● Evaluation and treatment (copy of sleep study requested)

VIRGINIA TMJ

FACIAL PAIN AND SLEEP CENTER

Dr. Manvitha Kuchukulla, MDS
TMJ and Orofacial Pain Specialist

Dr. Jaahnavi Kodali, DMD
TMJ and Orofacial Pain Specialist