Ortho Place
For happier smiles!

Request for Oral Medicine TMD/Orofacial Pain Consultation

Dr. Vandana Singh

BDS, MSc, MMSc, Oral Medicine Specialist FRCD(C)

Patient Name

D.O.B. *(MMDDYY)*

Patient's Email

Contact Phone Number

Address

AHS #

Gender

Age

Please fill out the following information to help us in providing patient with the best possible care

Medical History

Medications

Reason for Referral

☐ Oral Mucosal Lesions ☐ TMJ Pathology ☐ Sleep Medicine

☐ Burning Mouth ☐ Neuromodulators ☐ Headache / Migraine

Radiographs or Clinical Photos

PAN PERIAPICAL CBCT

Referred by Dr. (Please Print)

Date (MMDDYY)

Phone #

Fax #

Practice ID

☐ Re-order referral sheets Note: Referral Sheet can be downloaded or submitted by website

If you have any questions, please feel free to contact our office.

Dr. Vandana Singh

5520 111 St, Edmonton, AB T6H 3E9 | T: 780.432.1832 | F: 780.432.1726
E: info.edmonton@orthoplace.ca | W: www.orthoplace.ca

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