Ottawa TMJ & Sleep Apnea Clinic

GENERAL DENTISTRY LIMITED TO TMJ & SLEEP APNEA MANAGEMENT

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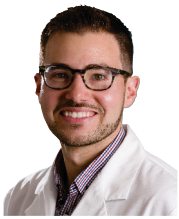

Referral Form to Dr. Dahan

Patient Name_____ Phone Number_____

Referring Doctor _____ Phone Number_____

REASON FOR REFERRAL

- ☐ Temporomandibular Disorder
- ☐ Headache/Migraine
- ☐ Sleep Apnea/Snoring
- ☐ Bruxism
- ☐ Botox

PANOREX

- ☐ Will email
- ☐ Please take one

COMMENTS

Doctor's Signature_____ Date _____