OFP, TMJ & DSM Specialists

Amit Wadke BDS, MS, MHA

Please submit your referral to:

Ph: (425) 322-1TMJ
Fax: (425) 297-4652
Email: info@ofp-specialists.com

Referring Clinician Information

Date: _____

Practice: _____

Phone: _____ Fax: _____

Clinician Name: _____

Signature: _____

Patient Information

Name: _____ DOB: _____

Phone: _____ Email: _____

Reason for Referral (check all that apply):

- ☐ Headaches
- ☐ Jaw Locking
- ☐ Pain Behind Eyes
- ☐ Dizziness/Vertigo
- ☐ Difficulty Swallowing
- ☐ Limited Mouth Opening
- ☐ Other Signs/Symptoms:

- ☐ Teeth Grinding/Clenching
- ☐ Neck, Shoulder Pain, or Stiffness
- ☐ Unexplained Teeth or Facial Pain
- ☐ Clicking, Popping, Crunching in TMJ
- ☐ Fullness, Ringing in Ears, or Earaches
- ☐ Sleep Disorders Evaluation for Oral Therapy

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Relevant History/Notes:

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Note: If available, please email or provide patient with copy of latest Panoramic Xray/CT Scan/MRI Scans.