UNIVERSITY of MARYLAND
SCHOOL OF DENTISTRY

Brotman Facial Pain Clinic
U.M.FDSP-Faculty Clinic
650 W. Baltimore St.
Baltimore, MD 21201
410 7067961/ 410 706 0309 Fax
FDS@umaryland.edu

Orofacial and Head Pain referral to Brotman Facial Pain Clinic Faculty Practice

PLEASE PRINT ALL INFORMATION LEGIBLY. Include letter of referral if more space is needed. This referral is required in order to make an appointment with us and should be submitted to FDS@umaryland.edu or fax at (410) 706-0309

Patient Name _____ Patient DOB _____

Patient Address _____Zip _____

Home Ph# _____Cell Ph# _____ Preferred #_____

Parent/Guardian Name if minor _____

Relation to Patient _____Parent/Guardian DOB _____

Referring Dentist/Physician Name: _____

Referring Dentist/Physician Address _____

_____ Zip _____

Referring provider Ph# _____FAX_____

Provider Signature: _____

Diagnosis/Symptoms/Reason for Referral _____

_____

_____

_____

Significant dental history relevant for CC_____

_____

_____

Significant medical history/relevant diagnosis_____

_____

_____

Please bring any night guard or mouth appliance currently in use as well as any relevant medical records about your pain condition such as, reports, laboratory results, imaging such as X-rays taken outside the school. Imaging accompanied by a radiologist report is preferred (e.g. MRIs, CBCT). Thank you.