

**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](mailto: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.