Berkshire Center for Craniofacial Pain
And
Dental Sleep Medicine

Craniofacial Pain and Sleep Apnea Patient Referral Form

Patient's name: _____ Date: _____

Phone number: _____ Date of birth: _____ female ☐
male ☐

Patient's chief compliant(s): (please check)

TMJ/Headache/Facial

__ Headache
___Face pain
___Jaw pain
___Problems opening and closing jaw
___Neck/shoulder pain or stiffness
___Clicking/joint sounds
___History of grinding or clenching teeth
___Ear pain
___Eye pain
___Dizziness
___Changes in bite/occlusion, pain in teeth, uncomfortable bite
___Stress: anxiety, depression, mood changes
___Any history of motor vehicle accident or trauma
___Sleep disorders
___Movement disorders
___Other_____

Obstructive Sleep Apnea

___Frequent loud snoring
___ Snoring that affects others
___Significant daytime sleepiness
___Been told they stop breathing
___Difficulty falling asleep
___Wake up gasping or choking
___Feeling tired in the morning
___Difficulty in concentration
___Morning headaches
___Depression or mood alternation
___Feel sleepy while driving
___Other_____

Referring provider's name: _____
Phone: _____
Email: _____
___Have Dr. Hyman call me
___You want us to call the patient for an appointment
___Patient will call our office

If you have questions or concerns, please call. Thank you for trusting us with the care of your patient.

Frederic P. Hyman D.D.S.
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