# LEDUC PHYSIO

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## REFERAL FORM

**Patient Name:** ______________________

*is experiencing:*

- ◯ Jaw pain
- ◯ Jaw clicking or popping
- ◯ Decreased ROM
- ◯ Earache or pain
- ◯ Headaches
- ◯ Facial pain
- ◯ Locking jaw
- ◯ Other:

**Previous Treatment(s):**

**Recommended Treatment(s):**

Signature ______________________

*Yes, Please provide report to (Dental Clinic Fax no.)* ______________________

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## POST-TREATMENT REPORT

**Patient Attended:**
- ◯ Physiotherapy
- ◯ Massage Therapy

**Date:** ______________________

**Notes/Treatment Plan:**

**Therapist Signature:** ______________________

**Therapist Name:** ______________________