Melbourne
TMJ & Facial Pain
Centre

PATIENT REFERRAL FORM

Date..

Patient Details

Name.. Date of Birth..................................

Address..

Phone Number...

Reason for Referral...

....

....

Investigations

Please send copies of relevant investigation results

Referrer Details

Name..

Medical / Dental / Other ....

Address for correspondence...

Phone Number...

PRACTICE STAMP

Please fax referral to 9824 8867 or
email info@melbournetmjcentre.com.au or
mail to 1199 High Street Armadale 3143

Thank you for entrusting us with your patient's care.
We appreciate your referral

Melbourne TMJ & Facial Pain Centre
1199 High Street, Armadale, 3143 **t:** 03 9824 8868
e: info@melbournetmjcentre.com.au **w:** melbournetmjcentre.com.au