Dr. Rolf Maijer, Inc.

Sleep, Pain and Fatigue Management

DENTIST REFERRAL FORM
FAX TO: 1-855-266-0505

PATIENT INFORMATION

Name: _____ DOB: _____

Address: _____ Home Ph: _____

City, Prov: _____ Cell Ph: _____

Postal Code: _____ Email: _____

Patient's MD: _____

REASON FOR REFERRAL

☐ Snoring ☐ Bruxing ☐ Chronic Fatigue

☐ Sleep Apnea ☐ Headaches ☐ _____

☐ Intolerance to CPAP ☐ Chronic Pain ☐ _____

Comments: _____

_____

SYMPTOMS

☐ Excessive Sleepiness ☐ Insomnia ☐ Restless Legs ☐ _____

☐ Daytime Fatigue ☐ Snoring ☐ Morning Headaches ☐ _____

☐ Non-Refreshing Sleep ☐ Witnessed Apneas ☐ Teeth grinding ☐ _____

MEDICAL HISTORY

☐ Sleep Apnea ☐ Heart disease *(detail below)* ☐ Diabetes ☐ Stroke

☐ Other Sleep Disorder _____ ☐ Stroke ☐ GERD

☐ Hypertension ☐ Cardiac Arrhythmia ☐ Depression ☐ Asthma

☐ Obesity ☐ Atrial Fibrillation ☐ Anxiety Disorder ☐ Chronic Pain

Medications: _____

PLANNED DENTAL TREATMENT

Is any dental treatment planned? ☐ Yes ☐ No Date of Last X-Ray: _____ ☐ Pan ☐ Ceph

If yes, please explain: _____

_____

REFERRING DENTIST

Dentist Name: _____ Address: _____

Office Phone: _____ _____

Office Fax: _____ Email: _____

Signature: _____ Date: _____

Follow-Up Communication: ☐ Report ☐ Phone call

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