



The TMJ and Sleep Therapy
Centre
of St. Louis

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Date: _____

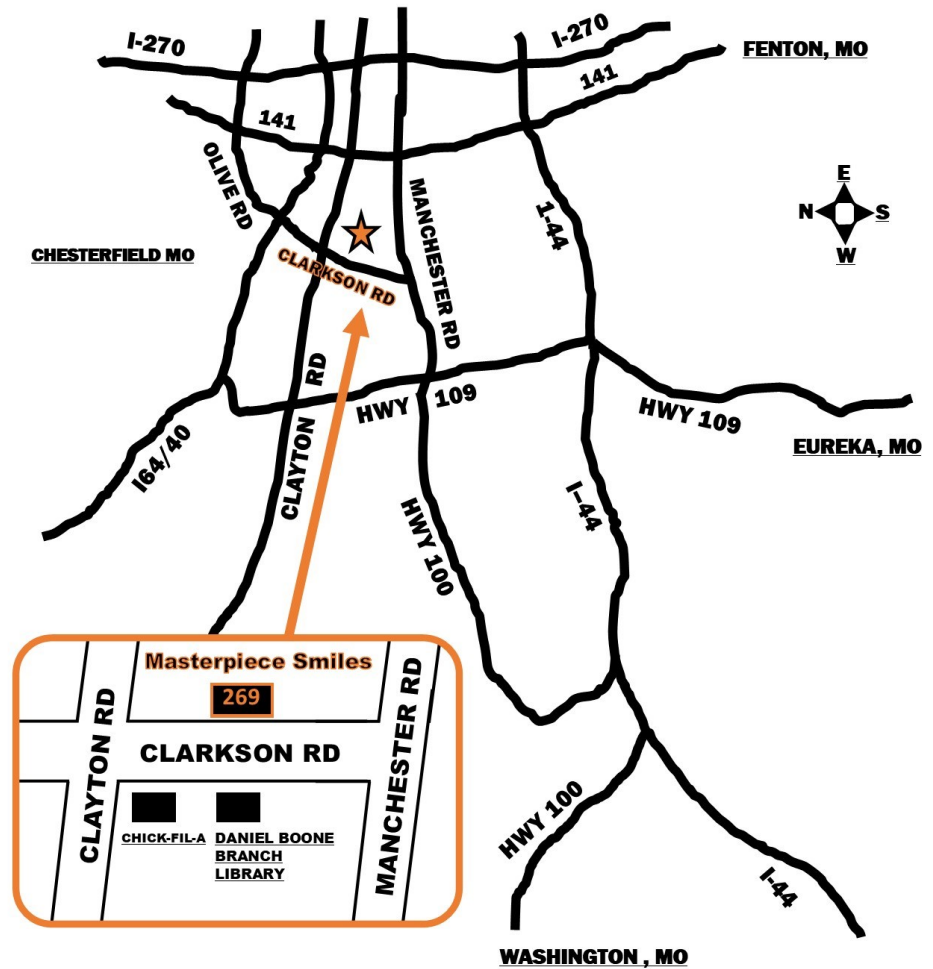
Patient's Name: _____

Phone: _____ **Email:** _____

Referring Doctor: _____

Reason(s) for Referral:

- ☐ Second Opinion / Consultation
- ☐ TMJ /TMD Evaluation
- ☐ Airway Concerns or Evaluation
- ☐ Clenching /Grinding / Teeth Wear
- ☐ 3D CBCT Scan (TMJ/Airway/Sinuses Analysis)
- ☐ TMJ/TMD Therapy with Day Orthotic & Night Sleep Appliance
- ☐ Dental Sleep Appliance
- ☐ Nightlase for Snoring
- ☐ Clear Aligner (Orthodontic) Expansion Technique
- ☐ Vivos DNA or mRNA Non-Surgical Jaw Expansion & Sleep Apnea Appliance
- ☐ Non-Cutting Laser Removal of Lip Hemangioma
- ☐ Reversal of Permanent Numbness with Prolozone and/or Laser Therapy
- ☐ Healing Laser Therapy/BioStimulation for Muscle/Nerve Pain
- ☐ Jaw Joint Vibration Test (TMJ Noises/Slipped Disc Analysis)
- ☐ Custom Ozone Trays for Teeth & Gum Health
- ☐ Other _____



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