# Patient Referral Form

Harter Dental | Thomas Harter, DMD | 2609 SW 33rd St, Suite 104-B, Ocala, FL 34471

**Fax completed form to: 352.581.6300  Phone: 352.203.4493**

## Referring Provider

**Provider name**

**Practice name**

**Phone**

**Fax**

**Email**

## Patient

**Patient full name**

**Date of birth**

**Patient phone**

**Patient email (optional)**

## Reason for Referral (check all that apply)

- ☐ Headaches or migraines
- ☐ Disturbed or restless sleep
- ☐ Daytime drowsiness
- ☐ Chronic pain
- ☐ Jaw pain or soreness
- ☐ Limited mouth opening
- ☐ Facial or unexplained dental pain
- ☐ General / restorative dental care
- ☐ Snoring / sleep apnea
- ☐ CPAP intolerance
- ☐ Earaches, fullness or ringing
- ☐ Neck, shoulder or back pain/stiffness
- ☐ Clicking or popping in jaw joints
- ☐ Jaw locking (open or closed)
- ☐ Difficulty swallowing
- ☐ Other (describe below)

**Notes / reason for referral (minimum necessary information)**

## Sleep apnea patients

To prescribe oral appliance therapy, please also complete our Medical Rx for Oral Appliance Therapy form (available on our For Providers page) and fax it with this referral.

**Referring provider signature**

**Date**

*Our team will contact the patient to schedule. Please send this form by fax or secure exchange (such as DDX), not by regular email. Hablamos Español.*