**ALI MAKKI, DMD**
**Headache & Facial Pain Disorders**

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# Consultation Request Form

**Date:** / /

| | |
|---|---|
| **Patient Information**<br>If Hoag referring, please attach label here: | **Name:**<br>Last_____ First_____<br>**DOB:** / / (mm/dd/yyyy)<br>Hoag Hospital MRN (if applicable)**:**_____<br>**Address:**<br>Street_____<br>City_____ State_____ ZIP_____<br>**Phone:** ( ) - |

***Please fax completed form to our office and give original to patient for appointment scheduling***

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|---|---|
| **Reason for Consultation** | **To be completed by referring provider** (*please mark all applicable boxes*):<br><br>**Orofacial:**<br>☐ Facial pain ☐ Idiopathic oral pain ☐ Oral/facial paresthesia ☐ Post-surgical oral pain<br>☐ Unresponsive dental pain ☐ Burning mouth/burning tongue ☐ Oromandibular dystonia<br>**Head & Neck:**<br>☐ Headache ☐ Cranial paresthesia ☐ Musculoskeletal pain ☐ TMJ pain/dysfunction<br>**Other:**<br>Presumptive diagnosis_____<br><br>Additional notes_____<br>_____<br>_____<br>_____<br><br>_____<br>**If specific studies and/or reports are available, please indicate below and request patient to hand deliver a copy to our office on the day of the appointment:**<br>☐ MRI ☐ CT ☐ Panoramic X-ray (OPG) ☐ Cone beam CT<br>☐ Clinical notes ☐ Labs ☐Other (please specify)_____ |
| **Referring Provider** | **Name:**<br>First_____ Last_____<br>Specialty_____ **Phone:** ( ) -<br>**Mailing address:** **Fax:** ( ) -<br>Street_____<br>City_____ State_____ ZIP_____<br>**Email address:** |