ANCHORAGE
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Orofascial Pain/ TMJ Referral

Tanya Smith PT, ScD, FAAOMPT

Patient Name: _____ Date: _____

Diagnosis: _____

DIAGNOSIS

- ☐ Atypical facial pain
- ☐ Subluxation/instability
- ☐ Headache
- ☐ Arthralgia
- ☐ Myalgia
- ☐ Tendinopathy
- ☐ Sprain
- ☐ DDWR
- ☐ DDWOR

PHYICAL THERAPY

- ☐ **EVALUATE AND TREAT**
- ☐ Trigger Point Dry Needling
- ☐ Oral Appliance Evaluation

I hereby certify that the above listed physical therapy modalities and procedures are medically necessary for treatment of this patient's diagnosis and condition.

Provider Name: _____ Date: _____