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**Refer your patients with confidence for the following conditions:**

- Myofascial pain
- Headache
- Phantom tooth pain
- Ear problems
- TMJ / TMD

**Patient Name:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Referring Doctor:** \_\_\_\_\_

**Notes:** \_\_\_\_\_

\_\_\_\_\_  
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**Please include your patients Phone # if you would like us to contact them**