

**Herman Ostrow School of Dentistry of USC**  
**Orofacial Pain and Oral Medicine Center**  
**Referral Form**

For making an appointment, please use our email address: [ofpomctr@usc.edu](mailto:ofpomctr@usc.edu)

For calling our front desk: **213.740.3410**

For sending reports to our clinic, please use our fax: **213.821.7870**

Our website is available for additional information: <https://ofpomcenter.usc.edu>

**Patient Name:**

**Date of Birth:**

**Reason for the referral (select all that apply):**

- ☐ Masticatory muscle pain
- ☐ Temporomandibular disorder (including painful opening and jaw noises)
- ☐ Temporomandibular joint arthritis
- ☐ Obstructive Sleep Apnea (requires statement of medical necessity and sleep study)
- ☐ Trigeminal neuralgia or neuropathy
- ☐ Burning mouth syndrome
- ☐ Dry mouth
- ☐ Persistent dental pain (no obvious dental pathology)
- ☐ Oral lesions (with no biopsy report)
- ☐ Oral lesions (with previous biopsy report)
- ☐ Bruxism (clenching or grinding)
- ☐ Other

**Proceed with (select all that apply):**

- ☐ Evaluate and treat
- ☐ Send a report (patient consent is required)
- ☐ Refer to other providers if needed.
- ☐ Other

Due to the history and examination, I am recommending this patient to be seen at the Orofacial Pain and Oral Medicine Center.

**Date**

**Referring Physician:**

**Physician's Signature (Initials if digital):**