



Queensland  
Government

**Metro South Health**

**Maxillofacial Surgery  
TMJ Referrals**

Facility: .....

(Affix identification label here or complete if E-Form)

URN:

Family name:

Given name(s):

Address:

Date of birth:

Sex:  M  F

**Breakdown of TMJ referrals to Maxillofacial Surgery PAH and LGH via Central Referral Hub**

In order for appropriate Maxillofacial Surgery TMJ referral triaging, the following information **must** be provided by all GPs/Dentists.

The referral will NOT be processed or accepted unless ALL points/questions are completed.

**TMJ specific**

Acute trauma

Contact relevant switchboard to speak with Maxillofacial Registrar on call

Any obvious/known Arthropathy anywhere

Direct to Maxillofacial via Central Referral Hub

**Chronic TMJ specific**

**Requirements / Questions**

**Completed:**

**Yes**

**No**

Plain imaging attached with report: OPG open and closed views



**Mouth opening measures between the teeth      cm      fingers**

- Pain lateral condyle TMJ
- Masseter pain/tenderness
- Temporalis pain/tenderness
- Headaches
- Neck pain
- Shoulder pain
- Any other history of arthropathy of other joints
- History of Auto Immune Disorders joints

DO NOT WRITE IN THIS BINDING MARGIN





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Completed by Facility

- Previous trauma joints

- Previous surgery on TMJ

- Ear Examination

**Yes / No**

- Previous history of facial pain syndromes joints

**Patient Details**

Name:

Address:

Date of Birth:

Medicare Number:

Valid to:

Pension Card:

Allergies:

**Referrer Details**

Name:

Signature:

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