SOURCE

OROFACIAL MYOFUNCTIONAL THERAPY

REFERRAL FORM

NAME: ______________________________ DOB: ____________________

EMAIL: ______________________________ PHONE: ____________________

REFERRED BY: ________________________ DATE: ____________________

REASON FOR REFERRAL: ____

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Please evaluate the following:

- ☐ Low tongue posture
- ☐ Restricted oral tissues
- ☐ Tongue thrust swallowing pattern
- ☐ Open mouth rest posture
- ☐ Mouth breathing

Other concerns noted:

- ☐ TMJD/discomfort/pain
- ☐ Sleep disordered breathing/snoring/sleep apnea
- ☐ Orthodontic relapse
- ☐ Tonsil/adenoid hypertrophy
- ☐ Headaches/clenching/grinding
- ☐ Other: ______________________________

Scan for more info:

Carly Williamson I (513)-512-5659 I info@sourcemyo.com