Kenora Smiles
Dentistry and Beyond

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Referral for Orofacial Myofunctional Therapy Assessment

Patient Name: _____ Date of Birth: _____

Address: _____ Home Phone: _____

City : _____ Postal Code: _____ Cell Number: _____

Email Address: _____ Parent/Guardian: _____

Date:_____ Referred by:_____

Areas of Concern (Check all that apply)

__ General Evaluation __ Tongue Thrust __ Speech concern __ TMJ concern

__ Head/Neck/Shoulder Pain/Tension __ Tongue-tie __ Lip tie __ Snoring/Sleep Concerns

__ Facial Muscle Dysfunction __ Low Tongue Posture __ Other

Notes: _____

_____

Relevant Health Information: _____

Other specialists seen: _____

Insurance Information:

Subscriber:_____ Ins Co. _____

DOB _____ Policy # _____ ID/Cert # _____

Kellie Brearley
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Orofacial Myofunctional Therapist
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