Hope
Integrative Therapy, PLLC

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Client Name: _____ DOB: _____

Parent/Guardian Name (for minor): _____

Phone: _____ E-mail: _____

Please evaluate and treat the following orofacial function concerns related to:

- ◯ feeding & swallowing
- ◯ speech
- ◯ tongue tie
- ◯ sleep
- ◯ mouth breathing
- ◯ tongue thrust
- ◯ thumb or finger sucking
- ◯ orthodontic relapse
- ◯ oral rest posture
- ◯ TMJ dysfunction
- ◯ other: _____

Referring Provider Name: _____

Referring Provider Signature: _____ Date: _____

Please send referral via e-mail to referrals@hopeintegrativetherapy.com