



OMD CHAIRSIDE SCREENING CHECKLIST

This checklist is intended to identify signs and symptoms of Orofacial Myofunctional Disorders (OMDs) to educate and support a referral.

**This is a screening tool and referral form and does not replace a comprehensive assessment by a trained provider.*

Patient Name:		Date of Birth (YYYY-MM-DD):	
Phone Number:		Parent/Guardian Name (if applicable):	

AIRWAY	
Quiet, easy nasal breathing	<input type="checkbox"/>
Audible nasal resistance with breathing	<input type="checkbox"/>
Quiet, mouth open breathing	<input type="checkbox"/>
Large oral isthmus (non-obstructive)	<input type="checkbox"/>
Small oral isthmus (obstructive tonsils)	<input type="checkbox"/>

ORAL HABITS	
No current or past oral habits	<input type="checkbox"/>
Thumb/Finger sucking	<input type="checkbox"/>
Nail biting	<input type="checkbox"/>
Pacifier	<input type="checkbox"/>
Feeding tools/pouches	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>

SLEEP	
Quiet, calm and restful	<input type="checkbox"/>
Frequent wakings	<input type="checkbox"/>
Restless	<input type="checkbox"/>
Odd positions	<input type="checkbox"/>
Bedwetting	<input type="checkbox"/>

ORAL REST POSTURE	
Tongue: Lingual palatal	<input type="checkbox"/>
Tongue: Against or between teeth (anterior/posterior/full)	<input type="checkbox"/>
Teeth: Slightly apart	<input type="checkbox"/>
Teeth: Excessively apart	<input type="checkbox"/>
Teeth: Clenching	<input type="checkbox"/>
Compensation: None	<input type="checkbox"/>
Compensation: Lower lip retraction	<input type="checkbox"/>
Compensations: Mentalis tension	<input type="checkbox"/>
Lips: Closed lip rest posture	<input type="checkbox"/>
Lips: Open lip rest posture	<input type="checkbox"/>

OTHER RED FLAGS	
No other red flags	<input type="checkbox"/>
History of frequent URI /	<input type="checkbox"/>
Drooling / bubbly speech	<input type="checkbox"/>
Messy eating	<input type="checkbox"/>
Restrictive / "picky eater"	<input type="checkbox"/>
Chapped lips	<input type="checkbox"/>
Sensitive gag	<input type="checkbox"/>
Difficulty with 1-minute	<input type="checkbox"/>
Difficulty managing saliva	<input type="checkbox"/>

JAW & DENTAL DEVELOPMENT	
Broad, u-shaped palatal arch	<input type="checkbox"/>
Narrow and/or V-shaped	<input type="checkbox"/>
Spacing between primary	<input type="checkbox"/>
Crowding	<input type="checkbox"/>
No occlusion concerns	<input type="checkbox"/>
Malocclusion: overbite, deep	<input type="checkbox"/>
Dental attrition	<input type="checkbox"/>



SWALLOW PATTERN	
Teeth closed, tongue up and back, effortless, no perioral tension	<input type="checkbox"/>
Tongue pushes forward, laterally or bilaterally with the swallow	<input type="checkbox"/>
Lower lip retraction or other perioral tension with the swallow	<input type="checkbox"/>

ARTICULATION & INTELLIGIBILITY	
100% intelligible by age 4 to unfamiliar listeners	<input type="checkbox"/>
Articulatory imprecision, lisp and/or difficulty with /s/ /z/ /r/ /l/ /sh/ /ch/	<input type="checkbox"/>
Reduced intelligibility / hard to understand / mumbly speech	<input type="checkbox"/>

LINGUAL MOBILITY & DISSOCIATION	
x-spot hold: Tongue tip isolated, tongue stable, mouth wide open	<input type="checkbox"/>
x-spot hold: Tongue blade is used vs tip	<input type="checkbox"/>
x-spot hold: Tongue touches teeth	<input type="checkbox"/>
x-spot hold: Poor lingual stability (poor endurance, tongue folds forward)	<input type="checkbox"/>
x-spot hold: Tongue doesn't reach x-spot / mouth closes	<input type="checkbox"/>
Tongue wags: Tongue moves laterally, separate from lips and jaw	<input type="checkbox"/>
Tongue wags: Lips and/or jaw move with the tongue	<input type="checkbox"/>
Caves: Tongue easily maintains lingual-palatal suction	<input type="checkbox"/>
Caves: Difficulty maintaining lingual-palatal suction	<input type="checkbox"/>
Caves: Palatal accommodation overflow	<input type="checkbox"/>

★ IF YOU SEE PINK, YOU HAVE TO THINK! ★

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This checklist can also act as a referral form: Please complete and send to **info@airwaycareomt.com** if you would like to refer this patient for an OMT assessment. Our OMT services are offered virtually across Canada.

I confirm the patient is aware of this referral

Clinic Name:	
Clinic Email:	
Clinician Name:	
Clinician Signature:	