OPTIMIZED AIRWAYS
MYOFUNCTIONAL THERAPY

(913)701-7033
AUDREY@OPTIMIZEDAIRWAYS.COM

VIRTUAL AND IN-PERSON APPOINTMENTS

REFERRAL FORM

CLIENT NAME:
PHONE:

DATE:

TYPE OF REFERRAL:

- ☐ CHILD
- ☐ TEEN
- ☐ ADULT

CONCERNS TO BE EVALUATED:

- ☐ TONGUE TIE
- ☐ TONGUE THRUST
- ☐ TONGUE PLACEMENT
- ☐ HABIT ELIMINATION
- ☐ SLEEP/GRINDING/ SNORING
- ☐ MOUTH BREATHING/ OPEN LIPS POSTURE

COMMENTS:

REFERRING PROVIDER: