MYOADVANTAGE

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REFERRAL MYOFUNCTIONAL THERAPY

Patient Name: _____ Date: _____

Parent Name: _____ Patient DOB: _____

Phone: _____ Email: _____

Referring Provider: _____

Please evaluate and treat the following Orofacial Myofunctional Disorders:

- ☐ Tongue Thrust
- ☐ Lingual Frenum/Tongue Tie
- ☐ Oral Rest Posture
- ☐ Snoring/Sleep Apnea
- ☐ Abnormal Swallow
- ☐ Thumb/Finger Habit
- ☐ Mouth Breathing
- ☐ Bruxism
- ☐ Other: _____

Comments: _____

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_____

MYOADVANTAGE.COM

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Please email referrals to infomyoadvantage@gmail.com