KEY MYOFUNCTIONAL
THERAPY, LLC

Patient Referral

Date of Referral: _____

Patient Name: _____ Date of Birth: _____

Responsible Party: _____ Phone: _____

Patient Email: _____

Referring Provider: _____ Phone: _____

Provider Email: _____

Referred For: (Check all that apply) (Optional: provide description)

- o Mouth Breathing:
  _____
- o Tongue Posture (e.g., low, thrust):
  _____
- o Oral Habits (e.g., thumb sucking):
  _____
- o Poor Sleep Quality / Snoring:
  _____
- o Tongue / Lip Tie Evaluation:
  _____
- o Orofacial Pain / Asymmetry:
  _____
- o Co-managed Conditions: OSA, TMD, Tinnitis, Forward Head Posture
  _____
- o Other:
  _____
  _____

Providers, please send referral via secure Email: info@keymyo.com

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