20055 SW Pacific Hwy. Suite 106 Sherwood, OR 97140

Ph. (503) 610-6145 | Fax (971) 979-1097

www.TheABClinic.com

Orofacial Myology Referral Form

Patient's Full Name:

Parent or Guardian's Full Name:

Patient's DOB:

Patient's address:

Patient's Phone:

Insurance Carrier:

Member ID:

Group Number:

Referring Dentist/Provider's Full Name:

Referring Dentist/Provider's phone:

Referring Dentist/Provider's Email:

Practice Name:

Practice address:

Practice Fax #:

Reason for Referral: (check all that apply)

- mouth breathing
- tongue thrust
- snoring
- teeth grinding

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teeth clenching

jaw pain

headaches

speech concerns

swallowing concerns

ortho/treatment relapse

sleep apnea

sleep disordered breathing concerns

tethered oral tissue

noxious oral habits

Other: (please list any other concerns and descriptions)

Speech-Language Pathology Service(s):

Evaluation only

Evaluation and Treatment

Dental/Orthodontic History, presenting symptoms, current or previous appliances:

Other concerns:

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_______________________________________ _______________________________

Physician/Referring Provider's Signature Date

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Physician/Referring Provider's NPI #

Please Fax To: (971) 979-1097 OR upload to patient portal on www.TheABClinic.com/Patient-Portal