DATE:_____
PATIENT NAME:_____
BIRTHDATE:_____
REFERRING PROVIDER:_____

PLEASE EVALUATE FOR THE FOLLOWING:

- ☐ Complete Myofunctional Evaluation
- ☐ Tongue Tie
- ☐ Abnormal Swallow/Tongue Thrust
- ☐ Low Tongue Posture
- ☐ Thumb Sucking
- ☐ Mouth Breathing/Open Mouth Posture
- ☐ Snoring/Sleep Issues
- ☐ TMJ Pain/Dysfunction
- ☐ Other:_____

Additional Information:_____
_____
_____

Melissa Lacek, RDH, OMT
Telehealth Provider/Virtual Visits
azmyo.com
(602) 805-7050

SCAN FOR MENU
USE THE CAMERA ON YOUR PHONE

Referring professionals: Please email a copy of this completed form along with any important documentation and notes to info@azmyo.com. Thank you!