Orofacial Myofunctional Therapy Referral Form

Date:_____

Patient Name: _____ Age: _____

Parent/Guardian: _____

Phone Number: _____

Email: _____

Referring provider: _____

Reason for Referral:

- o Mouth Breathing
- o Snoring
- o Teeth clenching/grinding
- o Jaw pain
- o Tongue thrust
- o Orthodontic support
- o Sleep apnea
- o Sleep disordered breathing concerns
- o Tongue tie
- o Thumb, pacifier or other non-nutritive oral habit elimination

Other comments or concerns:

_____

_____

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