Tracey Brizendine COM®

Orofacial Myofunctional Therapy Referral Form

Date: _______________ Patient Name: ____ Date of Birth: ____________________

Parents or Responsible Party Name: ____

Address ____ Phone ____

Referred by: ____ Phone: __________________________

Patient Email Address: ____

Main Concern: ____

Panorex ____________ CBCT __________________Airway Volume______________ Ceph________________________

Mouth-Breathing: _____________ Poor Tongue Rest Posture: ____________ Restricted Nasal Airway: ______________

Short Lingual Frenum: _________ Short Labial Frenum: __________________ Speech Concerns: ____________________

Relapse of Dental Bite: _________ TMJ Symptoms: _______________________ Intermolar Width____________mm

HIgh Resolution Pulse Oximetry or PSG: _______________ OSA: ________________UARS: ____________

Has patient had orthodontics_______________________ Has the patient had orthodontic expansion______________

Class I Class II Class III Crossbite: Right Left Overjet Open Bite Narrow Arches

Additional Comments____

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