# Tracey Brizendine C.O.M.®

## Rest Posture and Buteyko Breathing Referral Form

Date: _____ Patient Name: _____ Date of Birth: _____

Parents or Responsible Party Name: _____

Address _____ Phone _____

Referred by: _____ Phone: _____

Patient Email Address: _____

Main Concern: _____

Panorex Date _____ CBCT Date_____Airway volume _____mm2 Cephalogram Date_____

Surgery Scheduled Yes No Date of surgery _____ Surgeon's Name _____

Mouth-Breathing: _____ Poor Tongue Rest Posture: _____ Restricted Nasal Airway: _____

Short Lingual Frenum: _____ Short Labial Frenum: _____ Speech Concerns: _____

Relapse of Dental Bite: _____ TMJ Symptoms: _____ Allergies: _____

Airway Disorder: _____ OSA: _____UARS: _____ Weight Issues: _____

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

**TELEHEALTH**

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