Oral Function SPECIALTIES
Connecting oral health and wellness through a lifetime

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Referral for comprehensive myofunctional evaluation

Patient's Name: _____ **DOB:** _____

Referral Provider: _____ **Follow-up date:** _____

Diagnosis: _____

Precautions/comments: _____

Provider concerns

- ☐ Low tongue posture
- ☐ Mouth breathing
- ☐ Oral ties
- ☐ Strong gag reflex
- ☐ Orthodontic issues
- ☐ Tongue thrust
- ☐ Clenching/grinding
- ☐ Thumb/finger sucking
- ☐ Patient/parent request
- ☐ Other:

Patient concerns

- ☐ Headaches/migraines
- ☐ Neck, shoulder pain
- ☐ TMJ pain
- ☐ Clicking or popping in TMJ
- ☐ Snoring/sleep apnea
- ☐ Disturbed restless sleep
- ☐ Earaches
- ☐ Eating/swallowing issues
- ☐ Other:

_____ _____

Signature **Date**