OROFACIAL MYOLOGY
EDMONTON

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Orofacial Dysfunction Referral Form

Date:_____ Patient's name: _____ Age: _____

Parent: _____ Telephone number: _____

Referred by: _____ Telephone number: _____

Main Concern:

_____

_____

_____

_____

Symptoms:

_____ Mouth Breathing

_____ Tongue Thrust Swallow

_____ Allergies

_____ Relapse of Dental Bite

_____ Thumb Sucking

_____ Tongue Sucking

_____ Poor Rest Tongue Posture

_____ Speech Concerns

_____ Short Lingual Frenum

_____ TMJ Symptoms

_____ Finger Sucking

_____ Class I _____ Class II _____ Class III

_____ Cross bite _____ Lt _____ Rt

_____ Overjet _____ Open Bite