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Orofacial Dysfunction Referral Form

Date:_____________ Patient's name: _________________________ DOB: __________

Parent: _____________________________ Ph #: _______________________

Referred by: _________________________ Clinic Ph#: ____________

Clinic Name:_________________________

Main Concern:

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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