REFERRAL FORM

LITTLE ARBOR
SPEECH THERAPY

Thank you for referring your patient to our office. In an effort to provide the best service possible, we ask that you thoroughly complete this form.

Dr. ______________________________ would like to introduce

Patient: ______________________________ D.O.B: ______________

for evaluation and treatment of a possible orofacial myofunctional disorder.

CHECK ALL AREAS YOU WANT EVALUATED FOR YOUR PATIENT:

- ☐ Thumb/ Finger/ Nail biting
- ☐ Sucking habit
- ☐ Airway
- ☐ Tongue / Lip tie
- ☐ Tongue thrust
- ☐ Tongue rest position
- ☐ Articulation and speech sounds
- ☐ Other: ___________________________

CONCERNS:

- ☐ Class II
- ☐ Class III
- ☐ Open Bite
- ☐ Deep Bite
- ☐ Overbite
- ☐ Overjet
- ☐ Crossbite
- ☐ Crowding
- ☐ Impacted
- ☐ Missing Teeth
- ☐ TMD
- ☐ Other: _____________________

REMARKS AND ADDITIONAL INFORMATION:

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PATIENT CONTACT:

Phone #: ______________________

Guardian Name (if minor): ______________________

REFERRING DR.'S SIGNATURE

____

Date: ______________ Phone #: ______________

Email: ______________________________

Little Arbor Speech Therapy
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