www.restoremyohealth.com

Myofunctional Therapy Referral Form

Patient Information

Full Name: ____

Age: ____

City: _____________________________ State: ______________

Phone Number: _______________________________________

Email Address: ____

Referring Practitioner Information

Referring Practitioner Name: __________________________

Practice Name: ______________________________________

Phone Number: ______________________________________

Email Address: ____

Reason for Referral

Please indicate the primary reasons for referral:

- [ ] Airway/Breathing concerns
- [ ] Sleep concerns
- [ ] Tongue/Swallowing concerns
- [ ] Orthodontic relapse
- [ ] Other: _________________________________

*Please include any additional information that may assist in patient assessment:

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