

Airway, Snoring, TMJ, Tethered Oral Tissues, and Myofunctional Therapy Referral

Date: _____ Patient DOB: _____

Patient Name: _____

Address: _____

Phone: _____

Referring Provider: _____

Office Phone: _____ Provider Email: _____

Referring Provider's Area of Specialty: _____

Overnight Attended Sleep Study/Polysomnogram **Already Done**
 Needed

Reason for Referral: _____

Medical History and Pertinent Physical Exam Findings:

		Symptoms
<p>Lips</p> <ul style="list-style-type: none"> <input type="checkbox"/> Open posture at rest <input type="checkbox"/> Lip strain with lip seal <input type="checkbox"/> Lip ties <input type="checkbox"/> Crusty, dry lips <p>Facial</p> <ul style="list-style-type: none"> <input type="checkbox"/> Narrow smile <input type="checkbox"/> Long face height <input type="checkbox"/> Flattened cheeks <input type="checkbox"/> Eye shiners - dark circles under the eyes <input type="checkbox"/> Bags under eyes <input type="checkbox"/> Facial asymmetry <input type="checkbox"/> Gummy smile <p>Malocclusions</p> <ul style="list-style-type: none"> <input type="checkbox"/> Crowded/crooked teeth <input type="checkbox"/> Crossbite <input type="checkbox"/> Open bite <p>Growth & Development</p> <ul style="list-style-type: none"> <input type="checkbox"/> Under growth curve <input type="checkbox"/> Arrested growth <input type="checkbox"/> Lower jaw set further back than upper jaw or overbite <input type="checkbox"/> Weak chin - lower jaw retruded <input type="checkbox"/> Maxilla retruded 	<p>Tongue</p> <ul style="list-style-type: none"> <input type="checkbox"/> Restricted lingual frenulum <input type="checkbox"/> Forward tongue resting posture <input type="checkbox"/> Scalloped tongue <p>Imaging (CBCT or Ceph)</p> <ul style="list-style-type: none"> <input type="checkbox"/> Narrow posterior air space <input type="checkbox"/> Nasal resistance <input type="checkbox"/> Vertical position of the hyoid (should be C4, lower not good) <p>Intra-Oral Exam</p> <ul style="list-style-type: none"> <input type="checkbox"/> High narrow palate <input type="checkbox"/> Swollen tonsils & adenoids <input type="checkbox"/> Excessively worn teeth <p>Chronic otitis</p> <ul style="list-style-type: none"> <input type="checkbox"/> Speech problems <input type="checkbox"/> Poor eating & swallowing <input type="checkbox"/> Parafunctional habits <input type="checkbox"/> Increased BMI <input type="checkbox"/> Mouth Breathing or Dry Mouth <p><input type="checkbox"/> Comments _____</p> <p>_____</p> <p>_____</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Difficulties breastfeeding <input type="checkbox"/> Dysphagia <input type="checkbox"/> Snoring <input type="checkbox"/> Tooth grinding <input type="checkbox"/> Coughs, Colds, and Chest infections <input type="checkbox"/> Chronic allergies <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Snoring and fatigue <input type="checkbox"/> Asthma symptoms <input type="checkbox"/> Cognitive communication deficits <input type="checkbox"/> Poor academic performance <input type="checkbox"/> Language delays <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Frequent nightmares <input type="checkbox"/> Nocturia <input type="checkbox"/> Child behavioral disorders <input type="checkbox"/> Aggressive behavior <input type="checkbox"/> Irritability <input type="checkbox"/> Possible dx of ADD or ADHD <input type="checkbox"/> Restless Sleep <input type="checkbox"/> Eczema