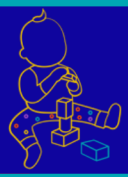
MYO REFERRAL FORM



not too little speech therapy, llc
CHALLENGING MYTHS - CHANGING LIVES

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 and fax it back to 1-702-549-7717

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:

_____

_____

PATIENT CONTACT:

Phone #: _____

Guardian Name (if minor): _____

REFERRING DR.'S SIGNATURE

X _____

Date: _____ **Phone #:** _____

Email: _____

not too little speech therapy, llc
Phone: 702-527-3142 Fax: 1-702-549-7717 Email: contact@nottoolittle.com