Orofacial Muscle Dysfunction Referral

Referring Provider: _____ Phone #: _____

Patient Name: _____ Phone #: _____

DOB/Age: _____ Parent Name (if patient is a minor): _____

- ☐ Mouth Breathing
- ☐ Restricted Labial Frenum
- ☐ Restricted Lingual Frenum
- ☐ Low/Forward Tongue Rest
- ☐ Post Orthodontic Relapse
- ☐ Snoring
- ☐ TMJD Symptoms
- ☐ Speech Concerns
- ☐ Atypical Swallow (a.k.a. “Tongue Thrust”)
- ☐ Habit Elimination:
  - ☐ Nail Biting
  - ☐ Thumb/Finger Sucking
  - ☐ Object Sucking/Chewing
  - ☐ Other: _____

Comments: _____

_____

_____

_____

Referring Provider Signature: _____ Date: _____

Phone: (615) 647-9009
Fax: (615) 667-9533

Request an Appointment:
https://omt-of-nashville.clientsecure.me

info@OMTofNashville.com