Whitefish Myofunctional Therapy

Referral Form

Date ____________________
Referring Healthcare Provider Name: ____
Introducing (patient) ___________________________ for evaluation of orofacial myofunctional disorders, swallowing habits, sucking habits, or other. M_______F______ DOB ______________Age_______
Parent(s) if minor__________________________________Phone______________Email______________________ ___________

Primary Reason for Referral:

- Ortho Relapse M26.11
- Tongue Thrust R13.11
- Atypical Swallow R13.11
- Oral Habits/Digit Sucking M26.59
- Low Tongue Rest Posture M26.59
- Dentofacial Functional Abnormalities M26.50
- Tongue Tie/Ankyloglossia/TOTS Q38.1
- Orofacial Muscle Pain M26.29
- Speech Disturbances R47.9
- Mouth Breathing R06.5
- Other Breathing Issues/Snoring R06.89
- Other, Please Describe: ______________________________________

- Has the patient had an airway screening? Yes No
- Has the patient had a Cranial 3D image? Yes No
- Has the patient had a sleep study? Yes No

Doctor/Provider, what objectives do you hope to accomplish with myofunctional therapy?________________________
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What is your timeline for treatment?

- I am waiting for you to finish therapy.
- I am willing to phase treatment in order to accommodate therapy.
- I am placing an orthodontic appliance and need to coordinate therapy.
- Not applicable

Signature of Provider____
E-Mail____ Phone______________________________

Next Step: Call me to discuss findings and treatment recommendations

Send me your Evaluation by: ___ mail ___ email

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Note to Provider:
The airway must be clear for successful orofacial myofunctional therapy (OMT). If tonsils/adenoids, turbinates, septal deviation or any other structural processes inhibits breathing, OMT will be limited in success. OMT is dependent on the ability of the patient to breathe with the mouth closed through the nose. OMT does address breathing re-education if the patient can nasal breathe most of the time and the airway is clear.