Friday Harbor Myofunctional Therapy

Referral Form

Date ____________________

Referring Healthcare Provider Name: ____

Introducing (patient) ___________________________ for evaluation of orofacial myofunctional disorders.

M_______F______ DOB ______________Age_______ Email:

Parent(s) if Minor: _________________________________ Phone:______________

Reason For Referral:

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

Primary goal(s) you hope to accomplish with Orofacial Myofunctional Therapy ?________________________

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Request:

- o **Short Consult to see if Comprehensive Evaluation is Needed**

  Comprehensive Evaluation and Report

  Comprehensive Evaluation, Report and Program as Indicated

- o **Please Call to Discuss**

Signature of Provider (if needed for insurance): ____

Email____ Phone______________________________

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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.