Patient Referral Form

Patient First and Last Name: ______________________________

Guardian First and Last Name (if patient under 18): ______________________________

Email Address (Guardian's if applicable): ______________________________

Cell Phone (Guardian's if applicable):______________________________

Referrer's Name, Office/Business Name, Email, and Phone Number: ______________________________

Please Select the Reason for Referral (Check all that apply):

- ❏ Thumb/Object Sucking
- ❏ Nail Biting/Ice Chewing
- ❏ Tongue Thrust/Open Bite
- ❏ Obstructive Sleep Apnea
- ❏ Child/Adolescent Bedwetting
- ❏ Crooked/Crowded Teeth
- ❏ Underdeveloped Upper/Lower Jaw
- ❏ Snoring
- ❏ Tongue Tie/Lip Tie/Cheek Tie
- ❏ Orthodontic Relapse
- ❏ Sleep Study
- ❏ Clenching/Grinding
- ❏ Excessive Daytime Sleepiness
- ❏ Hyperactivity/Trouble Focusing
- ❏ Migraine/Headache
- ❏ Mouth Breathing
- ❏ TMJ Discomfort/Jaw Pain
- ❏ Breastfeeding Difficulties
- ❏ Neck/Shoulder Discomfort
- ❏ Facial Aesthetic Services

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