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Airway/TMJ Request Referral Form

Patient Name: ______________________ **DOB:** ____________ **Age:** ____________
Parent/Guardian's Name(s): ______________________________________
Phone: ____________________ **Email:** ______________________________
Referring Provider: ____________________________ **Phone:** ________________
Email: ____________________ **Chief Concern:** ___________________________

- ☐ 1. MOUTH BREATHING VS. NASAL BREATHING
- ☐ 2. OPEN MOUTH POSTURE
- ☐ 3. TONGUE THRUST – ANTERIOR
- ☐ 4. BI-LATERAL TONGUE THRUST
- ☐ 5. TONGUE TIE
- ☐ 6. LIP TIE
- ☐ 7. ATYPICAL SWALLOWING
- ☐ 8. HABITS
- ☐ 9. CHEWING DISORDERS
- ☐ 10. FACIAL MUSCLE DYSFUNCTION
- ☐ 11. HYPOTONIC MASSETERS
- ☐ 12. SPEECH MISARTICULATIONS (LISPS)
- ☐ 13. TONSILS / ADENOIDS
- ☐ 14. TMJD
- ☐ 15. SLEEP DISORDERS / SLEEP APNEA
- ☐ 16. BRUXISM/CLENCHING
- ☐ 17. LOW TONGUE REST POSTURE
- ☐ 18. SNORING
- ☐ 19. MALOCCLUSIONS
- ☐ 20. CAVITIES AND GUM DISEASE
- ☐ 21. CHANGES IN SALIVA QUANTITY & QUALITY
- ☐ 22. RESTRICTED MAXILLA / HIGH PALATE
- ☐ 23. TONGUE SCALLOPING
- ☐ 24. CRANIOFACIAL DYSFUNCTIONS
- ☐ 25. ALLERGIC SHINERS / VENOUS POOLING
- ☐ 26. EUSTACHIAN TUBES DYSFUNCTIONS
- ☐ 27. ESTHETIC CHANGES
- ☐ 28. MACROGLOSSIA
- ☐ 29. ABNORMAL BREATHING
- ☐ 30. TINNITUS
- ☐ 31. INFANT FEEDING PROBLEMS
- ☐ 32. FORWARD HEAD POSTURE / POSTURE

Notes: ____

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