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Infant Referral Form

Patient Name: _____ **DOB:** _____ **Age:** _____
Parent/Guardian's Name(s): _____
Phone: _____ **Email:** _____
Referring Provider: _____ **Phone:** _____
Chief Concern: _____

☐ **TONGUE TIE**

☐ **LIP TIE**

☐ **CHEEK TIE**

☐ **FEEDING/LATCHING PROBLEMS**

☐ **OPEN MOUTH POSTURE/MOUTH BREATHING**

☐ **TONGUE THRUST**

☐ **LOW TONGUE REST POSTURE**

☐ **COLIC, HEAVY BREATHING, SNORING, SLEEP CONCERNS (circle all that apply)**

Did Patient Receive Vitamin K Injection: ☐ **Yes** ☐ **No**

Notes: _____