Friday Harbor Myofunctional Therapy

Referral Form

Date _____
Referring Healthcare Provider Name: _____
Introducing (patient) _____ for evaluation of orofacial myofunctional disorders, release prep or sucking habit elimination. M_____F_____ DOB _____Age_____
Parent(s) if minor:
_____Phone_____Email_____

Reason(s) 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
- ○ Other (Please Describe):
- ○ 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

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, what objectives do you hope to accomplish with myofunctional therapy?_____
_____
_____

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 after treatment.
- ○ Not applicable

Signature of Provider_____
E-Mail_____ Phone_____
Next Step: ___ Call me to discuss findings and treatment recommendations
___ Send a report of your evaluation by: ___ mail ___ email

Lori Miller RDH, COM®
Certified Orofacial Myologist
lori@fridayharbormyo.com

685 Spring St PMB 266
Friday Harbor, WA 98250
360-317-7444

Note to Provider:
The airway must be clear for successful orofacial myofunctional therapy (OMT). OMT does address breathing re-education if the patient can nasal breathe most of the time and the airway is clear. Structural issues (such as palatal width, tonsils/adenoids, turbinates or septal deviation) may need to be addressed to accomplish goals.