I am referring:

Name: ____

DOB: ____ Age: _______________________

Parent: ____

Phone: ____

Reason for Referral:

- ○ Tongue Thrust
- ○ Orthodontic Relapse
- ○ Mouth Breathing
- ○ Low tongue posture
- ○ Thumb Sucking/oral habit
- ○ TMJ Muscular pain

○ Other (Please describe) ____

Other Pertinent Information:____

____

Referring Dr.____

Address:____

Phone:___________________________________ **FAX:**______________________________

Sandie Weitemier BSDH, COM®

IAOM Board Certified Orofacial Myologist™

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