# Nerissa Boggan, BSDH, AOMT-C®, COM®

## Oral Myofunctional Therapy Referral Form

Date: ___/____/____

Patient Name: _____. Date of Birth: _____

Parents or Responsible Party Name: _____

Address _____ Phone _____

Referred by: _____ Phone: _____

Patient Email Address: _____

Reason for Referral/Prescription: (Please circle one or more.) *

Orofacial Myofunctional Examination and/or Therapy Drooling
Abnormal Swallowing Patterns and/or Tongue Thrust Non-nutritive Sucking Habit
Mouth Breathing and/or Open-lips Resting Posture Poor Tongue Rest Posture
Restricted Lingual Frenum Restricted Nasal Airway
Palatal Arch Low Palatal Arch Flat Palatal Arch Narrow Palatal Arch High
Other Concerns: _____

Orthodontic/Dental History: _____

If applicable: Retainer: Removable/Bonded Bands Bite Plate Tongue/Thumb Appliance

Surgery Scheduled Yes __ No __ Date of surgery ___/___/___ Surgeon's Name _____

Panorex Date __/__/__ CBCT Date __/___/___ Cephalogram Date ____/_____/____

Short Lingual Frenum: _____ Short Labial Frenum: _____ Speech Concerns: _____

Relapse of Dental Bite: _____ TMJ Symptoms: _____ Allergies: _____

Airway Disorder: _____ OSA: _____UARS: _____ Digestive Issues: _____

Class I Class II Class III Crossbite: Right Left Overjet Crossbite Open Bite

**nbogganrdh@alumni.ucsf.edu Phone: (925) 962-7450**

**LAFAYETTE and WALNUT CREEK**