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oasis
FAMILY DENTAL CENTRE

Orofacial Myofunctional Referral Form

Patient Name: _____ DOB: _____

Parent(s)/Guardian Name(s): _____

Home Phone: _____ Cell: _____

Email Address: _____

Address:

REASON for Referral:

_____

_____

_____

Occlusion:

___Normal Occlusion ___Class I Malocclusion ___Class II Malocclusion ___Class III Malocclusion

___Crossbite: ___Bilateral ___Unilateral: ___R ___L

Overjet:

___Within Normal Limits ___mm

Overbite:

___Within Normal Limits ___mm

Facial Profile: ___convex ___concave ___WNL

Current or Future Orthodontic Procedures/Considerations (please include plans for palatal expansion and type of appliance to be used):

_____

_____

_____

Other significant findings:

_____

_____

_____

_____