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Tongue thrust, articulation, language and /k/ommunication

Talk SLP LLC

From: Dr _____

Patient's Name: _____ **DOB**: _____

Date of Examination: _____

Parent(s) or Guardian: _____

Address: _____

Telephone: (H) _____ (W) _____

I. Reason for Referral/Prescription: (Please check one or more.)

- ☐ Orofacial Myofunctional Examination and/or Therapy
- ☐ Speech/Language Evaluation/Therapy
- ☐ Abnormal Swallowing Patterns and/or Tongue Thrust
- ☐ Non-nutritive Sucking Habit
- ☐ Mouth Breathing and/or Open-lips Resting Posture
- ☐ Restricted Lingual Frenum
- ☐ Palatal Arch ☐ low ☐ flat ☐ narrow ☐ high

II. Orthodontic/Dental History:

III. Presenting Symptions:

- ☐ Class 1 ☐ Class II ☐ Class III
- ☐ Open Bite ☐ Cross Bite ☐ Overbite ☐ Overjet

IV Treatment Plan: ☐ Active ☐ Proposed

Check if applicable:

- ☐ PE ☐ Retainer: Removable/Bonded ☐ Bands ☐ Bite Plate ☐ Tongue/Thumb Appliance
- ☐ Other:

Additional Concerns:

Signature **Date**