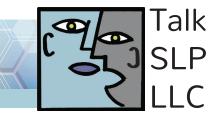
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From: Dr					
Patient's Name:					
Date of Examinati	on:				
Parent(s) or Guardian:					
Address:					
Telephone: (H)			(\\/)		
I. Reason for Refe	rral/Prescripti	on: (Please che	eck one or more.)		
Orofacial Myofunctional Examination and/or Therapy				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 Syn	nptions:				
Class 1	Class II	Class III			
Open Bite	Cross Bite	Overbite	Overjet		
IV Treatment Plan	n: A	active	Proposed		
Check if applica	ble:				
PE Re	Retainer: Removable/Bonded Bands E				Tongue/Thumb Appliance
Other:					
Additional Concer	ms [.]				