Harmony Myofunctional Therapy
780-238-2335
reception@harmonymyotherapy.com
harmonymyotherapy.com

PATIENT REFERRAL FORM

Patient Name: _____ **Date:** _____

Age / D.O.B.: _____ **Parent / Guardian:** _____

Contact Number: _____ **Email:** _____

Address: _____

Reason for Referral

Restrictive Frenulum

- ☐ Sublingual
- ☐ Maxillary Labial
- ☐ Mandibular Labial
- ☐ Buccal

Oral Habits & Function

- ☐ Tongue-Thrust
- ☐ Mouth Breathing
- ☐ Improper Tongue Posture
- ☐ Speech Concerns

Additional Concerns

- ☐ Habit Elimination
- ☐ Dysfunctional Breathing: Buteyko
- ☐ TMJ/Facial Pain
- ☐ Other: _____

Comments

Referring Provider & Provider Contact

Submit Form

Thank you for your referral. We are grateful for your trust in Harmony Myofunctional Therapy and for the opportunity to be part of your collaborative care team. Working alongside dedicated clinicians like you is at the heart of what we do, and we look forward to supporting your patient.

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