Referral Form

Please fill out the following information. Fax the completed form to **763-755-4261**

Patient's Name _____ **DOB** _____

Parent or Guardian *(if child)* _____

Phone _____

Date of referral _____

Dentition *(circle)* Openbite - Overjet - Overbite - Crossbite - High Palate

Class 1 2 3 - Other _____

Please mark your concerns

___ Open Mouth Posture
___ Oral breathing
___ Low Muscle Tone
___ Tongue Thrust
___ Digit Habits
___ Speech (Articulation) Concerns
___ Anterior Tie
___ Posterior Tie
___ Lip Tie
___ TMJ Pain

Comments_____

_____

_____

Referring Professional _____

Phone _____ **Fax** _____

Email _____

Thank you for your referral. We'll call your patient to schedule an evaluation.