# 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.