



Airway/TMJ Request Referral Form

Patient Name: _____ DOB: _____ Age: _____
Parent/Guardian's Name(s): _____
Phone: _____ Email: _____
Referring Provider: _____ Phone: _____
Email: _____ Chief Concern: _____

- | | |
|---|--|
| <input type="checkbox"/> 1. MOUTH BREATHING VS. NASAL BREATHING | <input type="checkbox"/> 17. LOW TONGUE REST POSTURE |
| <input type="checkbox"/> 2. OPEN MOUTH POSTURE | <input type="checkbox"/> 18. SNORING |
| <input type="checkbox"/> 3. TONGUE THRUST - ANTERIOR | <input type="checkbox"/> 19. MALOCCLUSIONS |
| <input type="checkbox"/> 4. BI-LATERAL TONGUE THRUST | <input type="checkbox"/> 20. CAVITIES AND GUM DISEASE |
| <input type="checkbox"/> 5. TONGUE TIE | <input type="checkbox"/> 21. CHANGES IN SALIVA QUANTITY & QUAL |
| <input type="checkbox"/> 6. LIP TIE | <input type="checkbox"/> 22. RESTRICTED MAXILLA / HIGH PALATE |
| <input type="checkbox"/> 7. ATYPICAL SWALLOWING | <input type="checkbox"/> 23. TONGUE SCALLOPING |
| <input type="checkbox"/> 8. HABITS | <input type="checkbox"/> 24. CRANIOFACIAL DYSFUNCTIONS |
| <input type="checkbox"/> 9. CHEWING DISORDERS | <input type="checkbox"/> 25. ALLERGIC SHINERS / VENOUS POOLING |
| <input type="checkbox"/> 10. FACIAL MUSCLE DYSFUNCTION | <input type="checkbox"/> 26. EUSTACHIAN TUBES DYSFUNCTIONS |
| <input type="checkbox"/> 11. HYPOTONIC MASSETERS | <input type="checkbox"/> 27. ESTHETIC CHANGES |
| <input type="checkbox"/> 12. SPEECH MISARTICULATIONS (LISPS) | <input type="checkbox"/> 28. MACROGLOSSIA |
| <input type="checkbox"/> 13. TONSILS / ADENOIDS | <input type="checkbox"/> 29. ABNORMAL BREATHING |
| <input type="checkbox"/> 14. TMJD | <input type="checkbox"/> 30. TINNITUS |
| <input type="checkbox"/> 15. SLEEP DISORDERS / SLEEP APNEA | <input type="checkbox"/> 31. INFANT FEEDING PROBLEMS |
| <input type="checkbox"/> 16. BRUXISM/CLENCHING | <input type="checkbox"/> 32. FORWARD HEAD POSTURE / POSTURE |

Notes: _____

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GERRI HUBERMAN DMD