REVEAL
MYO THERAPY

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Consultation Referral Form

Referring Professional: _____ Date: _____

E-Mail: _____ Phone: _____

Client Name: _____ DOB: _____

Phone: _____

Indication for Myofunctional Disorder Consult

- ☐ Mouth Breathing
- ☐ Low Resting Tongue Posture
- ☐ Snoring
- ☐ Sleep Disordered Breathing/ Sleep Apnea
- ☐ Frequent Headaches
- ☐ Anxiety
- ☐ ADHD
- ☐ Depression
- ☐ TMJ Pain/Dysfunction
- ☐ Clenching/Grinding
- ☐ Head/Neck/Back Pain
- ☐ Poor Posture
- ☐ Sleep Disturbances
- ☐ Chronic Fatigue
- ☐ Sinus Congestion/ Drainage
- ☐ Speech Discrepancies

OTHER: _____

Referring professionals:
Please forward a completed copy of this form to Sara@RevealMyoTherapy.com along with any relevant documentation and notes. Thank you.