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Magnolia Ridge DENTISTRY

Patient Referral Form

Patient: _____ **Date of Birth:** _____

Parent/Guardian: _____ **Phone:** _____

Reason for referral ("X" all that apply)

☐ Infant Frenectomy ☐ Child Frenectomy ☐ Airway Exam ☐ Orthodontic Treatment ☐ Other: _____

Details about referral ("X" all that apply)

☐ Snoring ☐ Nursing issues ☐ Feeding issues ☐ Mouth Breathing ☐ Dental Malocclusion ☐ Obstructive Sleep Apnea (enclose sleep study) ☐ Speech Problems ☐ Cranial Malformation ☐ Other: _____

Patient Has:

☐ IBCLC ☐ SLP ☐ OMT/Myofunctional Therapist ☐ ENT ☐ Sleep Physician ☐ Other: _____

Clinical Findings:

Airway: Intermolar width ___mm (target ___mm) | Pharyngeal space ___mm ☐ Enlarged tonsils (Grade ___) ☐ Enlarged adenoids ☐ Blocked turbinates ☐ Tongue tie (Grade ___) ☐ High narrow palate ☐ Class II ☐ Class III

Referred by: _____ **Phone:** _____

Date: _____ **Email:** _____

☐ Will send report ☐ Would like a report back ☐ Patient will call to schedule ☐ Please call patient

Enclosed: ☐ Patient Report ☐ Sleep Study ☐ Other: _____

Please email report to: info@magnoliaridgedentistry.com
or fax to: (469) 209-6388

Thank you for your referrals