Ann Lalezarian, RDH,MS,OMT

OROFACIAL MYOLOGY CONSULT

Patient's Name _____ Age _____ Date _____

Phone numbers (H)_____ (Cell) _____ (Other) _____

Referring
Practitioner _____

Dear _____:
Please see the above named patient for brief Orofacial Myology evaluation, paying special note to areas checked.

_____ Position of tongue and lips at rest
_____ Lip Strength Meter reading
_____ Mouth Breathing
_____ Lingual frenulum
_____ Sucking habits
_____ Other:

Recommendations:

_____ Full Orofacial Myology evaluation
_____ Unplugging The Thumb program
_____ Evaluation not needed at this time
_____ Return for full exam after orthodontic intervention
_____ Other (please feel free to elaborate any concerns)

_____
_____
_____

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