My MouthWorks Referral Form

1. Please complete the information and:

   - Scan, email, or fax the form to our office at Info@it4k.com

2. Please provide the patient/parent with a copy and to contact Innovative Therapy for an appointment.

3. Please include any pictures or pertinent X-rays.

Thank you for allowing us the opportunity to serve your patients!

TODAY'S DATE: _____ Patient's Name: _____

Patient's Telephone: _____ Patient's Email: _____

Referring Dentist/Orthodontist/Physician/Therapist:

_____

_____

_____

PATIENT HAS BEEN SEEN FOR THE FOLLOWING:

	General Orthodontic Evaluation		Habit Correction Treatment
	Early Interceptive Treatment		Dentofacial Orthopedics
	Temporo-Mandibular Disorder		Other

PATIENT CONCERNS:

	Airway/Sleep		Dental Crowding		Openbite
	Snoring		Dental Spacing		Overbite
	Swallowing Difficulty		Speech Disorder		Crossbite
	Headaches/Migraines		Thumb/Finger Habit		Underbite
	TMJD/Clenching/Grinding		Restorative Considerations		Tongue Thrust
	Postural Issues		Body Pain		Other:

Innovative Therapy
Innovative Oral Solutions, Inc.
5804 Van Allen Way, Carlsbad CA 92008
P: 760-438-3300 F: 760-438-3320
E: Info@it4k.com

REQUESTING:

	Myo/Rhino Assessment		Speech Assessment
	Swallowing Assessment		Postural Assessment
	Body Pain Assessment		MMW Health Platform
	In person Treatment		

SPECIAL INSTRUCTIONS OR REMARKS:

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