SCHNEIDER OROFACIAL MYOLOGY

Carly Schneider RDH/COM
Certified Orofacial Myologist
Breathing Specialist

Patient Referral

Name:________________________ Birth Date: __________ Number: __________ Email: ________________________

Areas Of Concern:

- ☐ Tongue Thrust
- ☐ Swallowing/Eating Problems
- ☐ Swollen Tonsils
- ☐ Speech
- ☐ Digestion Problems
- ☐ Congestion
- ☐ Sleep Apnea
- ☐ Allergies
- ☐ Asthma
- ☐ Mouth Breathing
- ☐ Dental Malocclusion
- ☐ Temporal Mandibular Joint Disorder
  - ☐ Clenching ☐ Grinding
- ☐ Open Mouth Resting Posture
- ☐ Oral-Facia Related Habits __________

☐ Pain ______________________________________ ☐ Restricted Frenum _________________________________

☐ Other ____

Referring Doctor: ____ Referral Date: ______________________

Special Instructions: ____

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San Rafael
1050 Northgate Rd. Ste 250 B
San Rafael, CA 94903

Mill Valley
147 D Lomita Drive
Mill Valley, CA 94941

San Francisco
390 Laurel St. Ste 310
San Francisco, CA 94118

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California State law requires that this written order be presented at time of appointment. Fees are payable at the time services are rendered. We accept VISA, MC, Cash & Check. Cancellations without 48 hour notice are subject to charges.