

|  |  **TIP OF THE TONGUE****OROFACIAL MYOFUNCTIONAL REFERRAL**80 300 Donlevy Avenue, Red Deer, AB403-391-1413 info@tipofthetongue.ca |
| --- | --- |

 **Client Name**: First Name Last Name

 First Last

**Date of Birth:**  Year Month Day

 YR / MM / DD

**Parent Name:** Parent Name

**Mailing Address:** Mailing Address

City or Town Province Postal Code

**Phone Number:**  Phone Number

**Client Email Address:**  Email

**Malocclusion/Reason for Referral/Comments (Please send client photos to**

**info@tipofthetongue.ca** **along with this referral):**

| Click here to enter text. |
| --- |

**Current or Prescribed Orthodontic Treatment:**

| Click here to enter text. |
| --- |

**Referring Dentist:** Click here to enter.

**Date of Referral:**  Click here to enter a date.

***Upon receipt of referral Tip of the Tongue will contact the client to schedule an appointment. Thank you for your referral and collaborative care for our clients.***

www.tipofthetongue.ca