

|  | **TIP OF THE TONGUE**  **OROFACIAL MYOFUNCTIONAL REFERRAL**  80 300 Donlevy Avenue, Red Deer, AB  403-391-1413 [info@tipofthetongue.ca](mailto:info@tipofthetongue.ca) |
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**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**](mailto:info@tipofthetongue.ca) **along with this referral):**

| Click here to enter text. |
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**Current or Prescribed Orthodontic Treatment:**

| Click here to enter text. |
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**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