



**UPNORTH SERVICE REFERRAL FORM**

**PATIENT & PRIMARY CONTACT INFO**

Patient Details		Primary Contact Details			
<b>Name</b>		<b>Name</b>		<b>Relation</b>	
<b>DOB</b>		<b>Phone</b>		<b>Email</b>	
<b>Dx Code</b>		<b>Address</b>			

**REFERRING PROVIDER**

<b>Provider Name</b>			<b>Phone</b>		
<b>Clinic Name</b>			<b>Email</b>		
<b>Type of Provider</b>	<input type="checkbox"/> Dentist   Orthodontist <input type="checkbox"/> Chiropractor	<input type="checkbox"/> IBCLC   CLC <input type="checkbox"/> ENT	<input type="checkbox"/> SLP <input type="checkbox"/> OT	<input type="checkbox"/> PT <input type="checkbox"/> MD/NP (PCP)	<input type="checkbox"/> Massage Therapist <input type="checkbox"/> Pediatrician

**REASON FOR REFERRAL**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Oral Habits                   | <input type="checkbox"/> Specific Speech Errors     | <input type="checkbox"/> Restriction Released |
| <input type="checkbox"/> Oral Dysfunction              | <input type="checkbox"/> Early Language Development | <input type="checkbox"/> TMJ Concerns         |
| <input type="checkbox"/> Feeding & Swallowing Concerns | <input type="checkbox"/> Assess for Restriction     |   |
| <input type="checkbox"/> Infant Feeding Concerns       | <input type="checkbox"/> Sleep Disordered Breathing |   |

**SPECIFIED HABITS | SYMPTOMS**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Mouth Breathing                | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Labial Frenum(s)         |
| <input type="checkbox"/> Low/Interdental Tongue Posture | <input type="checkbox"/> Snoring               | <input type="checkbox"/> Buccal Frenum(s)         |
| <input type="checkbox"/> Tongue Thrust                  | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Picky/Messy/Noisy Eating |
| <input type="checkbox"/> Dental   Ortho Regression      | <input type="checkbox"/> Drooling              | <input type="checkbox"/> Frequent Congestion      |
| <input type="checkbox"/> Teeth Grinding/Clenching       | <input type="checkbox"/> Lingual Frenum        |   |

**Notes:**

**Provider Signature**

Provider Name

Today's Date

**Please send this form along with any relevant medical details by FAX: 701-786-6099 or EMAIL: [info@upnorththerapies.com](mailto:info@upnorththerapies.com)**

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