UPNORTH THERAPIES
CRAFTING CONFIDENCE THROUGH
DYNAMIC ORAL FUNCTION

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UPNORTH SERVICE REFERRAL FORM

PATIENT & PRIMARY CONTACT INFO

Patient Details		**Primary Contact Details**			
Name		**Name**		**Relation**	Choose from Dropdown
DOB		**Phone**		**Email**	
Dx Code		**Address**			

REFERRING PROVIDER

Provider Name			**Phone**		
Clinic Name			**Email**		
Type of Provider	☐ Dentist | Orthodontist ☐ Chiropractor	☐ IBCLC | CLC ☐ ENT	☐ SLP ☐ OT	☐ PT ☐ MD/NP (PCP)	☐ Massage Therapist ☐ Pediatrician

REASON FOR REFERRAL

- ☐ Oral Habits
- ☐ Oral Dysfunction
- ☐ Feeding & Swallowing Concerns
- ☐ Infant Feeding Concerns
- ☐ Specific Speech Errors
- ☐ Early Language Development
- ☐ Assess for Restriction
- ☐ Sleep Disordered Breathing
- ☐ Restriction Released
- ☐ TMJ Concerns

SPECIFIED HABITS | SYMPTOMS

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

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