Best Speech Therapy, PLLC
15150 Preston Road, Ste 300
Dallas, Texas 75248
214-997-1106
888-240-3680

info@bestspeechtherapy.com
www.bestspeechtherapy.com

1. Please enter your information.

Client's Name: ____________________ Date of Birth: ____________

Gender:
○ Female ○ Male ○ Other

Age ____________

Responsible Party Name ____________________

Mobile Phone: ____________ Email: ____________________

Provider's Name ____________ Physician Office Phone ____________

Physician Fax Number ____________ Physician Office Email Address ____________

Brief Summary of Referral Doctor's treatment plan/summary ____________________

2. Reason for Referral

- ☐ Tongue Tie /Tethered Oral Tissues ____________
- ☐ Mouth Breathing ____________
- ☐ Low Tongue Posture ____________
- ☐ Orthodontic Relapse ____________
- ☐ Tongue Thrust ____________
- ☐ Oral Habits ____________
- ☐ Snoring ____________
- ☐ Improper Tongue Posture ____________
- ☐ Chewing/Feeding Issues ____________
- ☐ Tongue Thrust Swallow ____________
- ☐ Food Aversions ____________
- ☐ Speech Concerns ____________
- ☐ TMJ/TMD ____________
- ☐ Articulation ____________
- ☐ Feeding/Swallowing Concerns ____________
- ☐ Voice Concerns ____________
- ☐ Other ____________

Additional Information

____

3. Clinical Records

Last Clinical Examination Report and/or strobe images for Voice patients; any additional clinical examination information pertinent to referral