OMD/ Oral Rest Posture Referral

Client Name: _____ _____
First *Last*

Date of Birth: _____
Year/ Month/ Day

Parent Name[s]: _____

Mailing Address: _____
Address

_____
City/Town *Province* *Postal Code*

Phone Number: _____

Malocclusion: ☐ Class I ☐ Class II ☐ Class III

☐ Div. I ☐ Div. II

Comments: _____

_____

Current or Prescribed Orthodontic Treatment: _____

_____

Referring Dentist/Orthodontist: _____

Date of Referral: _____
Year/ Month/ Day

Previous Speech-Language Pathology Treatment: ☐ Yes ☐ No

Oral Photos provided: ☐ Yes ☐ No

Please fax the completed form to: S.L. Hunter SpeechWorks at 905.637.4995
4B-5195 Harvester Rd. Burlington, ON L7L 7K9 | www.slhunterspeechworks.com | info@slhunter.ca