MarvelMyo & Speech

Online Orofacial Myofunctional, Feeding, and Speech Therapy for All

Referring Provider Information

Name: _____

Clinic Name: _____

Phone: _____

Email: _____

Patient Information

Patient Name: _____

Date of Birth: _____

Parent/Guardian (if minor): _____

Phone: _____

Email: _____

Reason for Referral

- ☐ Orofacial Myofunctional Concerns
- ☐ Feeding Difficulties (infant, child, or adult)
- ☐ Tongue/Lip Tie Concerns
- ☐ Swallowing/Airway Function
- ☐ Speech Sound Concerns
- ☐ Sleep/Behavior Concerns Related to Oral Function
- ☐ Collaboration for Comprehensive Nutrition + Oral Motor Plan
- ☐ Other: _____

Additional Notes (if applicable):

_____

_____

_____

Has the patient been evaluated for tongue/lip tie by another provider?

☐ Yes ☐ No If yes, by whom? _____

Insurance Status:

☐ Private Pay ☐ In-Network Insurance (list carrier): _____

How to Refer

Please fax to 817-668-0288 or email securely to intake@marvelomt.com. We will contact the family within 1–2 business days to schedule an intake.