

# Lamberg Airway and Sleep: Data Collection & Referrals V8

- Cardiologist  
  Dentist  
  Dietician  
  Otolaryngologist  
  Pulmonologist  
 Orthodontist/Oral Surgeon  
  Oral Myologist  
  Neurologist  
  Psychologist

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_ Chief Complaint: \_\_\_\_\_

## VITAL SIGNS +

	Y	N				Y	N
Blood Pressure High ___/___	<input type="checkbox"/>	<input type="checkbox"/>	Neck	_____	Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>
Heart Rate High _____	<input type="checkbox"/>	<input type="checkbox"/>	Waist	_____	BMI > 30 _____	<input type="checkbox"/>	<input type="checkbox"/>
CVD Red Flags	<input type="checkbox"/>	<input type="checkbox"/>	Height	_____	Insomnia (ISI _____)	<input type="checkbox"/>	<input type="checkbox"/>
Neck/Height ≥ .21	<input type="checkbox"/>	<input type="checkbox"/>	Weight	_____	Rx Oral DNA (Bleeding on Probing)	<input type="checkbox"/>	<input type="checkbox"/>
Waist/Height > .55	<input type="checkbox"/>	<input type="checkbox"/>	ESS _____ LQ _____		Rx Comprehensive Dental Exam	<input type="checkbox"/>	<input type="checkbox"/>

## STRUCTURE (Anatomic)

<u>Clinical:</u>		Y	N		Y	N		Y	N
Tonsils Brodsky Grade 3 - 4	<input type="checkbox"/>	<input type="checkbox"/>	TMJ: Load Test +, Muscle Test +	<input type="checkbox"/>	<input type="checkbox"/>	Friedman Tongue Posture 3 - 4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cottle Maneuver +	<input type="checkbox"/>	<input type="checkbox"/>	Excess Wear, Recession, NCCLs	<input type="checkbox"/>	<input type="checkbox"/>	Mallampati Grade 3 - 4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged Uvula	<input type="checkbox"/>	<input type="checkbox"/>	Erosion	<input type="checkbox"/>	<input type="checkbox"/>	TRM: MOTIP/MIO < 50%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergic Shiners	<input type="checkbox"/>	<input type="checkbox"/>	More than 8 Missing Teeth	<input type="checkbox"/>	<input type="checkbox"/>	Gingival Display > 4mm _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dennie-Morgan Lines	<input type="checkbox"/>	<input type="checkbox"/>	Tongue Overflow Max Arch	<input type="checkbox"/>	<input type="checkbox"/>	Mew Indicator Line > 44mm _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PNIF < 100 l/m _____	<input type="checkbox"/>	<input type="checkbox"/>	Scalloped Tongue	<input type="checkbox"/>	<input type="checkbox"/>	Cricomental Space < 1.5cm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FEV1 < 80% _____	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged Sclera	<input type="checkbox"/>	<input type="checkbox"/>	Tori Max/Mand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lingual Inclination Mand Molars	<input type="checkbox"/>	<input type="checkbox"/>	Posterior Crossbite	<input type="checkbox"/>	<input type="checkbox"/>	Crowded Dentition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>Ceph:</u>		Y	N		Y	N		Y	N
SNA < 79° Deficient Maxilla	<input type="checkbox"/>	<input type="checkbox"/>	ANB > 5° Skeletal Class 2	<input type="checkbox"/>	<input type="checkbox"/>	NBC3 is <108° or >124°	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SNB < 76° Deficient Mandible	<input type="checkbox"/>	<input type="checkbox"/>	ANB < 1° Skeletal Class 3	<input type="checkbox"/>	<input type="checkbox"/>	Anterior Open Bite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
FH-MP > 27° Excess Vertical Growth	<input type="checkbox"/>	<input type="checkbox"/>	PV-A Line < 97mm Retrognathic Maxilla	<input type="checkbox"/>	<input type="checkbox"/>	Other Craniofacial Deficiencies: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<u>CBCT:</u>		Y	N		Y	N		Y	N
MP-H > 15mm _____	<input type="checkbox"/>	<input type="checkbox"/>	Intercuspid Distance < 29mm _____	<input type="checkbox"/>	<input type="checkbox"/>	Deviated Septum _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MinXA < 110mm _____	<input type="checkbox"/>	<input type="checkbox"/>	PHI (H/W x 100) > 42% _____	<input type="checkbox"/>	<input type="checkbox"/>	Septal Spur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intermolar Distance < 38mm _____ (between max 1st molars)	<input type="checkbox"/>	<input type="checkbox"/>	Dental Crowding	<input type="checkbox"/>	<input type="checkbox"/>	Enlarged Swell Body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intermolar Distance < 24mm+age (between primary 2nd molars <6 years)	<input type="checkbox"/>	<input type="checkbox"/>	Mucosal Thickening in Max Sinus	<input type="checkbox"/>	<input type="checkbox"/>	Concha Bullosa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			Hypertrophied Turbinates	<input type="checkbox"/>	<input type="checkbox"/>	Adenoids Enlarged	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## FUNCTION (Physiologic)

	Y	N		Y	N		Y	N
PCrit High	<input type="checkbox"/>	<input type="checkbox"/>	Loop Gain High	<input type="checkbox"/>	<input type="checkbox"/>	Dialator Muscle Response Low	<input type="checkbox"/>	<input type="checkbox"/>
ArTH Low	<input type="checkbox"/>	<input type="checkbox"/>						

## BEHAVIOR A (Habits)

	Y	N		Y	N		Y	N
Mouth Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Chest Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Low Tongue Resting Posture	<input type="checkbox"/>	<input type="checkbox"/>
Forward Head Posture	<input type="checkbox"/>	<input type="checkbox"/>						

## BEHAVIOR B (Muscle Function)

	Y	N		Y	N		Y	N
Lip Incompetence	<input type="checkbox"/>	<input type="checkbox"/>	Swallow Accompanied by Tongue Thrust	<input type="checkbox"/>	<input type="checkbox"/>	Overactive Perioral Musc. (incl. Mentalis) on Swallow or Lip Closure	<input type="checkbox"/>	<input type="checkbox"/>
Snoring (Palatal Flutter)	<input type="checkbox"/>	<input type="checkbox"/>						