



F.A.S.T. SCREENING FORM

Facial • Airway • Swallowing • Tongue Assessment
(Orthodontic • Airway • Functional Assessment)

PATIENT INFORMATION

Name: _____

DOB: ___ / ___ / ___ Age: _____

Date: ___ / ___ / ___

Parent/Guardian (if minor): _____

Primary Concern: _____

FACIAL & GROWTH ASSESSMENT

- Open mouth posture
- Lip incompetence
- Forward head posture
- Long/narrow face pattern
- Facial asymmetry
- Retrognathic mandible
- Maxillary deficiency
- Dark circles / allergic shiners
- History of chronic ear infections
- Other: _____

DENTAL & OCCLUSION

- Class I
- Class II
- Class III
- Anterior open bite
- Deep bite
- Crossbite (anterior/posterior)
- Crowding
- Spacing
- Narrow maxilla
- High/vaulted palate
- Orthodontic relapse
- Bruxism / clenching
- TMJ symptoms
- Gingival inflammation
- Other: _____

AIRWAY & BREATHING

- Nasal breathing
- Mouth breathing (day)
- Mouth breathing (night)
- Snoring
- Restless sleep
- Bedwetting
- Enlarged tonsils/adenoids
- History of airway obstruction
- Allergies
- Diagnosed OSA / UARS
- Daytime fatigue
- ADHD-like symptoms
- Other: _____

S SWALLOWING & SPEECH

- Atypical swallow
- Chewing dysfunction
- Picky/selective eating
- Gag reflex sensitivity
- Difficulty swallowing pills
- Speech sound errors
- Lisp
- Feeding history concerns
- Other: _____

T TONGUE & ORAL FUNCTION

- Low tongue rest posture
- Tongue thrust (anterior)
- Tongue thrust (lateral)
- Tongue tie (suspected)
- Limited tongue mobility
- Macroglossia
- Tongue scalloping
- Poor lip seal
- Drooling
- Other: _____

ADDITIONAL CLINICAL FINDINGS

RECOMMENDATION

- Further Comprehensive Orthodontic Evaluation? YES NO
- Airway-Focused Orthodontic Evaluation Recommended? YES NO
- CBCT Recommended? YES NO

INTERDISCIPLINARY REFERRALS (if indicated)

- ENT
- Myofunctional Therapy
- Sleep Medicine
- Pediatrician
- Speech Therapy
- Periodontist
- TMJ Specialist
- Other: _____

Provider Name: _____

Signature: _____