



Requirements for an ALF Mentorship Case Presentation

Step 1: Collect the photos, videos, and patient information as outlined below.

Step 2: At least two weeks before the Mentorship session, send an email request to drtashaturzo@gmail.com with the subject line 'ALF Mentorship Program Case Presentation Request'. Include in the email:

- Your Name, email, and contact phone number
- A link to a dropbox or google drive folder containing the information below.

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1. Assure you have the required documents for your country or state to share your patient's photos, videos and history. You may need to have your patient sign a "photo release" form.
 2. Full standing pictures with face forward and side profile view. Please make sure the patient have their shoes off, hair tied up and the neck is visible.
 3. Purchase a "postural grid" for the before and after pictures. Here is an example: <https://www.posturezone.com/products/Posture-Grid>
 4. Do not tell the patient to "stand up right".. but rather try to "capture" the "natural posture" of the patient.
 5. Close up picture of the face from both a forward and side profile. Make sure that the ears are visible. They are used as a reference point for symmetry.
 6. Intra oral photos including:
 - Anterior and side photos of occlusion
 - Open mouth view of posterior pharynx
 - Have the patient place their tongue to their upper palate to visualize the lingual frenulum.
 - Stand behind the patient and manually lift the tongue up to visualize the lingual frenulum.
 - Distraction upper and lower lip to view and take a picture of the upper and lower frenulum.
 - Upper arch and lower arch
 - Take the above pictures before placement of the ALF and after delivery of the ALF.
 7. Take all of the above pictures after each monthly ALF adjustments.



8. Video your patient walking, talking, chewing and swallowing. These video are short .. less than 10 seconds and only need to be taken with your initial visit.

Walking video: Have them walk down a hallway. Do not prompt them to walk a certain way.. we want to see what their overall natural movement is. Have them walk barefoot so we can see how their feet move.

Talking video: Have them say their name and how old they are (if they are a kid). What do they love to do in life. Have them say “Lucy Licked a Lollipop” and “Sally Sells Seashells down by the Seashore.” And “Genius Girls.”

Chewing video: Have them chew a cracker (can be organic and gluten free). Video the front of the face chewing and swallowing.

Swallowing video: Have your patient drink from a glass cup. Best if you video the side profile of the swallowing process.

9. Complete the patient evaluation form below.

PATIENT EVALUATION FORM FOR ALF

Name: _____ Age: _____ DOB: _____ Date: _____

Chief Complaint(s) : _____

1. Any complications during pregnancy. Did mom have an “airway” issue during pregnancy? Any snoring during sleep? Did mom take more than 10 courses of antibiotics? How is mom’s gut health?

2. Describe birth delivery: (Home or Hospital birth, Epidural or Pitocin, prolonged labor, C-Section (describe events which lead to C-Section) Did baby breath well after birth? Did they need oxygen at birth or need to stay in the hospital for care after birth?

3. _____

4. Breast fed? YES NO

5. Breast fed for how long: _____

6. Painful or noisy breast feeding? YES NO Explain: _____

7. Visit with lactation consultant? YES NO Explain: _____

8. Did the baby experience any colic? YES NO Explain: _____

9. Did baby spit up? YES NO Explain: _____

10. Supplemental bottle feeding? YES NO What formula was used?

11. At what age were solid foods introduced? _____

12. Crawling at what age? Did baby have a symmetrical crawl before standing _____

13. Walking at what age? _____

14. Any trouble with fine motor skill development? (tying shoes, coordination, etc.) YES NO

Explain: _____

15. What kind of illness did they child have? Sinus, throat or ear infections, stomach aches? Others?

16. Vaccinations? Any reactions to specific vaccinations? _____

17. History of any medications or antibiotics? _____

18. Any sucking habits? (Thumb, fingers, shirts, blankets, cheeks, pencils, etc.) _____

19. Sensory issues? (photo sensitive, noise, textures, etc.) YES NO Explain: _____

20. Messy eater, gulping while eating, fast/slow? YES NO Explain: _____

20. Hiccups with regularity? YES NO Explain: _____

21. Picky eater? YES NO Explain: _____

22. Any gagging? (pills, foods, drinks, etc.) _____

23. Gas or bloating? _____

24. Any problems with tonsils and adenoids? (Removed, constantly swollen, trouble swallowing, etc.)

25. Describe sleep? (how long, interrupted, difficulty to fall asleep or wake up, etc.) _____

26. Bed wetting issues? _____

27. Sleep posture? (on back, side, stomach, etc.) _____

28. Teeth grinding? YES NO Explain: _____

29. Snoring? YES NO Explain: _____

30. Sleep apnea? YES NO Explain: _____

31. Headaches? YES NO Explain: _____

32. TMD pain or clicking of joints? YES NO Explain: _____

33. Ear aches? YES NO Explain: _____

34. History of ear infections or tubes? YES NO Explain: _____

35. Breathing? (mouth, nasal, congested, difficulty, wheezing, etc.) _____

39. Allergies? YES NO Explain: _____

40. Any pets? YES NO Explain: _____

41. Posture assessment: (forward head posture, slouched, limp, etc.) _____

42. Any behavior or social issues? (ADD, ADHD, Autism, Ausberger's, etc.) _____

43. Any academic or learning issues? _____

44. Activities, sports, musical instruments? _____

45. Trauma history: Any visits to the ER? Any head injuries with bruising or loss of consciousness? Any falls on the face? Any injuries to teeth. Any injuries where the patient lost their breath? Any fractures or stitches?

For practitioner to fill out:

46. Lip posture? OPEN CLOSED

47. Gummy smile? YES NO

48. Palate size and shape? _____

49. Diastema's present? YES NO Where: _____

50. Tongue position? (low tongue posture, anterior thrusts, lateral thrusts, etc.) _____

51. Maxillary frenum: NORMAL MILD MODERATE HEAVY

52. Lingual frenum: NORMAL MILD MODERATE HEAVY

53. Crowding of maxillary teeth? _____

54. Crowding of mandibular teeth? _____

55. Open bite? YES NO

56. Deep bite YES NO

57. Cross Bite Anterior Posterior Left Righth

58. Tonsil Grade: _____

59. Malampati Score: _____

Attitude: Patient : _____ Parent: _____

Patient Goals: _____

Comments:

