Dreamhaven dental sleep medicine

Referral for Oral Appliance Therapy

To: Clinton L. Roberts, DDS

Oral Appliance Order Form:

Patient: _____ DOB: _____

Address: _____ Ht: _____

_____ Sleep Study Date: _____

Telephone: H)_____ AHI_____ RDI _____

C)_____ CPAP Pressure: _____

Diagnosis (Please check)

_____ Obstructive Sleep apnea

_____ Upper airway resistance syndrome

_____ Narcolepsy

_____ Periodic limb movement disorder

_____ Restless leg syndrome

_____ Other _____

Treatment Orders (Please check)

_____ Mandibular Advancement Device for treatment of OSA

_____ Mandibular Advancement Device to be used in combination with CPAP

_____ Positional Therapy (positional cushion to prevent supine sleep)

_____Other_____

Medical Justification (Patient has tried CPAP and has not tolerated and/or complied with treatment for the following reasons):

_____ Unable to tolerate mask/straps

_____ Unable to tolerate effective CPAP pressure

_____ Skin sensitivity

_____ Claustrophobia

_____ Other _____

Due to the history and diagnosis above, I am recommending oral appliance therapy for the treatment of this patient. I, the undersigned, certify the procedure prescribed above is medically necessary for the treatment of this sleep disorder.

Referring Physician: _____(print) Phone: _____

Signature: _____ Date: _____

Member: American Academy of Dental Sleep Medicine