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Referral For Oral Appliance Therapy

Patient Information

Patient Name:_______________________________ DOB:____________ Contact Phone: _________________
Address: ____
Email: ____

Sleep Physicians Diagnosis /Clinical Impression:

[ ] Snoring/ UARS [ ] Mild OSA [ ] Moderate OSA [ ] Severe OSA
[ ] CPAP Intolerance / Non-compliance AHI______ RDI_______ Epworth Score________

Sleep Study Available: Yes ☐ No ☐ Current C-PAP Pressure: __________ Auto-PAP ______

Referring Physician: (Please Print)____ NPI# _____________
Phone:______________________ Fax:_______________________ Email:_______________________

[ ] Patient satisfies the general requirements for oral appliance therapy. (See separate sheet)

Reason for Referral (Mark all that Apply)

☐ **Obstructive Sleep Apnea (ICD 327.23)**

☐ Insomnia due to Sleep Apnea (ICD 780.51)

☐ Sleep Apnea/Sleep Related Breathing Disorder, Unspecified (ICD 327.20)

☐ Hypersomnia due to Sleep Apnea (ICD 780.53)

☐ Other, Unspecified (ICD 780.57)

RX: ☐ **Fabricate Custom Oral Appliance**

Statement of Medical Necessity

This above patient has undergone a sleep study for a sleep related breathing disorder. This evaluation confirmed that an Oral Appliance is medically necessary. Oral Appliance Therapy (OAT) is used as an alternative to surgery at this time and or CPAP, as this patient could not tolerate CPAP or does not feel he/she will be able to tolerate CPAP.

Physician's Signature: ____ **Date:** ______________________