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Referral For Oral Sleep Appliance Therapy

Patient Information

Patient Name: _____
Address: _____
City & Zip: _____State _____
Cell #: _____
Home #: _____
Work #: _____
SSN: _____ DOB: _____

Patient's Insurance Information

Carrier: _____
Phone: _____
Group No: _____
ID No: _____
Person Insured: _____
Insured SSN: _____
Insured DOB: _____

Clinical Observations					
	Loud Snoring		Restless Sleep		Obese/Large neck
	Witness Apneas		High Blood Pressure		Dry Mouth
	Daytime Drowsiness		GERD		Regtrognathia
	Loss of Energy/Fatigue		Morning Headaches		Enlarged Tongue

Patient referred to Sleep and Snoring Solutions to be evaluated for oral appliance therapy (OAT) due to:

☐ The patient has been diagnosed with obstructive sleep apnea: *mild mod severe AHI:*_____
☐ CPAP Intolerance
☐ Primary Snoring
☐ Surgical Result Inadequate
☐ Adjunctive therapy to CPAP or Surgery
☐ Additional comments regarding patient's history of OSA therapy:

_____

- A copy of the following -if available- should be faxed to office prior to consult appointment:
  - The most recent **complete** diagnostic PSG (i.e., long report)
  - The summary CPAP trial PSG (if patient had one)

Referring Physician: _____
Office Address: _____
City & Zip: _____State _____
Office Phone: _____Office Fax: _____

Physician Signature: _____ **Date:** _____