

HEADACHES • FACIAL PAIN • NECK PAIN • TMJ DISORDERS • SLEEP APNEA

Rx for 1 Oral Appliance Therapy For Medically Diagnosed Obstructive Sleep Apnea

Introducing: _____ Referral Date: _____

Please provide treatment with oral appliance due to the following: (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> CPAP intolerant | <input type="checkbox"/> Primary snoring |
| <input type="checkbox"/> Mild/Moderate OSA | <input type="checkbox"/> Adjunct to CPAP therapy |
| <input type="checkbox"/> Insufficient surgical outcome | |
- Patient's Phone: _____ Please call patient to schedule appointment
 Patient will call to schedule their appointment

Comments: _____

Diagnosis

- Obstructive sleep apnea - G47.33
 Sleep apnea unspecified - G47.30
 Sleep related bruxism - G47.63
 Snoring - R06.83

Patient has a diagnostic polysomnogram report Yes No

Please fax to our office or provide patient with a copy

Physician Name: _____

Physician Signature: _____

Doctor's Phone: _____ Doctor's Fax: _____

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