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Referral for Oral Appliance Therapy

Oral Appliance Order Form:

Patient's Name:	Sex:
Date of Birth:	Height:
Weight:	Address:
Home Phone:	City, State, Zip:
Work Phone:	Sleep Study Date:
Cell Phone:	AHI:
Email:	RDI:
	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
___ Other _____
___ Skin Sensitivity
___ Claustrophobia

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: _____

Please call 920.788.6280 for an appointment.

Appointment Date: _____ Time: _____

Member of the AADSM & Wisconsin Sleep Society Member