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Recommendation for Oral Appliance Therapy

Oral Appliance Referral for:

Fax: (952) 920-0105

Patient: _____ DOB: _____

Address: _____ Ht: _____ Wt: _____

_____ AHI: _____ RDI: _____

City, State, Zip: _____ CPAP Pressure: _____

Telephone: (H) _____

(C) _____

Diagnosis (please check)

- | | |
|---|--|
| <input type="checkbox"/> Obstructive Sleep Apnea | <input type="checkbox"/> Periodic Limb Movement Disorder |
| <input type="checkbox"/> Upper Airway Resistance Syndrome | <input type="checkbox"/> Restless Leg Syndrome |
| <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Primary Snoring |

Treatment Orders (please check)

- Mandibular Advancement Device for treatment of OSA
- Mandibular Advancement Device to be used in combination with CPAP
- Mandibular Advancement Device for treatment of primary snoring
- Other _____

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

- | | |
|---|---|
| <input type="checkbox"/> Unable to tolerate mask/straps | <input type="checkbox"/> Skin sensitivity |
| <input type="checkbox"/> Unable to tolerate effective CPAP pressure | <input type="checkbox"/> Claustrophobia |
| <input type="checkbox"/> N/A | <input type="checkbox"/> Other Continuation of Care |

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. I understand the oral appliance will be needed for an indefinite period of time.

Referring Physician: _____ (print) Phone: _____

Signature: _____ Date: _____

NPI#: _____