



PATIENT REFERRAL

Sleep & Oral Appliance Evaluation

Thank you for your referral!

We appreciate the opportunity to partner in the care of your patients.
Please fax this form along with any available records.



Phone
(734) 335-0820



Fax
(734) 361-3948



Email
Hello@greatlakesairwayandsleep.com



Questions?
Feel free to contact us
anytime.

PATIENT INFORMATION

Name: _____
Date of Birth: _____ Phone: _____
Email (if available): _____
Address: _____

REFERRING PROVIDER / OFFICE INFORMATION

Office/Practice Name: _____
Referring Provider: _____
Phone: _____ Fax: _____
Email: _____
Address: _____

REASON FOR REFERRAL (Check all that apply)

- | | |
|---|--|
| ☐ Suspected sleep-disordered breathing / OSA | ☐ May need sleep testing (no current study) |
| ☐ Snoring | ☐ Daytime fatigue / sleep-related symptoms |
| ☐ Known obstructive sleep apnea | ☐ ATP/TMJ or bruxism (may be relevant) |
| ☐ CPAP intolerance / difficulty with PAP therapy | ☐ Existing oral appliance concern / replacement |
| ☐ Interested in oral appliance therapy | ☐ Evaluation of airway-related dental findings |
| ☐ Evaluation for oral appliance therapy | ☐ Co-management of existing OSA |
| ☐ Has an existing sleep study | ☐ Other: _____ |

RECORDS ENCLOSED (Check all that apply)

- | | |
|---|---|
| ☐ Sleep study (PSG or home sleep test) | ☐ Medication list |
| ☐ Sleep medicine notes | ☐ Dental records / radiographs |
| ☐ Prescription for oral appliance therapy (Rx) | ☐ Periodontal records / charting |
| ☐ Letter of Medical Necessity (LOMN) | ☐ PAP/CPAP compliance report |
| ☐ Relevant medical records / progress notes | ☐ Other: _____ |

ADDITIONAL COMMENTS

Thank you!

We value our relationships with our referring providers and look forward to working together for better sleep, better health, and better lives.