SNORING & SLEEP APNEA
DENTAL TREATMENT CENTER

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Recommendation for Oral Appliance Therapy

To: Jonathan A. Parker, DDS, DABDSM
Jeffrey S. Forslund, DDS, DABDSM
Benjamin R. Bowling, DDS, ABDSM Qualified

Oral Appliance Referral for: **Fax: (952) 920-0105**

Patient: _____ DOB: _____

Address: _____ Ht: _____ Wt: _____

_____ Sleep Study Date: _____

City, State, Zip: _____ AHI: _____ RDI: _____

Telephone: (H) _____ CPAP Pressure: _____

(C) _____

Diagnosis (please check)

_____ Obstructive Sleep Apnea
_____ Upper Airway Resistance Syndrome
_____ Narcolepsy
_____ Periodic Limb Movement Disorder
_____ Restless Leg Syndrome
_____ 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):

_____ Unable to tolerate mask/straps
_____ Unable to tolerate effective CPAP pressure
_____ N/A
_____ Skin sensitivity
_____ Claustrophobia
_____ 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#: _____