



SNORING AND SLEEP APNEA
DENTAL TREATMENT CENTER

Referral for Oral Appliance Therapy

To: Jonathan A. Parker, DDS

Oral Appliance Order Form:

Fax: (952) 920-0105

Patient: _____

DOB: _____

Address: _____

Ht: _____

Sleep Study Date: _____

Telephone: H) _____

AHI _____ RDI _____

C) _____

CPAP Pressure: _____

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"/> 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):

- | | |
|---|---|
| <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"/> Other _____ | |

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 for an appointment (952) 345-0290 Appointment Date: _____ Time: _____