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ORAL APPLIANCE REFERRAL FORM FOR MEDICALLY DIAGNOSED OBSTRUCTIVE SLEEP APNEA

Patient's Information

Full Name: _____
Last *First* *M.I.* *DOB*

Address: _____
Street Address *City* *State* *Zip*

Home Phone: _____ **Cell Phone:**_____ **Email:**_____

Medical Insurance: Medicare? ___**Yes** ___**No**

_____
Subscriber Name *ID Number* *Subscriber DOB*

_____
Employer Name *Group Number* *Policy Number* *Pt Relationship to Subscriber*

Requesting Physician's Name & Practice Name: _____

_____
Practice Phone **Practice Fax** **Physician Email**

Reason For Referral

Diagnosis

____**Obstructive Sleep Apnea (ICD G47.33)**

____**Insomnia due to Sleep Apnea (ICD G47.00)**

____**Hypersomnia due to Sleep Apnea (ICD G47.10)**

____**Apnea/Sleep Related Breathing Disorder, Other, Unspecified (ICD G47.30)**

Without Appliance (CPAP or Oral Appliance)

Respiratory Disturbance Index RDI _____ **Apnea Hypopnea Index (AHI)** _____

Lowest Desaturation (SpO2) _____ **Percentage or Amount of Time Below 90%** _____

Therapies Attempted

____ **CPAP** ____ **Intolerant to CPAP** ____ **Not A Good CPAP Candidate** ____ **Surgery**

_____ **Successful CPAP Pressure** **Other** _____

Comments /Concerns _____

Date of Sleep Test (Include Copy Of Sleep Test) _____

Statement Of Medical Necessity

This above patient has undergone a sleep study for a sleep related breathing disorder. This evaluation confirmed the diagnosis of obstructive sleep apnea. This evaluation confirmed that an Oral Appliance is medically necessary. Oral Appliance Therapy is used as an alternative to surgery at this timeand/or CPAP, as this patient could not tolerate CPAP or does not feel he/she will be able to tolerate CPAP.

_____

Physician Signature **Date**