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sleepbettersc.com

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 time and/or CPAP, as this patient could not tolerate CPAP or does not feel he/she will be able to tolerate CPAP.

____
Physician Signature **Date**