Dental

SLEEP MEDICINE

of Michigan P.C.

SNORING & SLEEP APNEA TREATMENT

Oral Appliance Order Form

Patient: ________________________________

Address: _______________________________

____

Telephone: H) ____________________

C) ____________________

DOB: ________________

Ht: _______ Wt: _______

Sleep Study Date: ________

AHI________ RDI________

CPAP Pressure: __________

Diagnosis (please check)

__ Obstructive sleep apnea

__ Upper airway resistance syndrome

__ Narcolepsy

__ Periodic limb movement disorder

__ Restless leg syndrome

__ 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:

__ Unable to tolerate mask/straps
__ Unable to tolerate effective CPAP pressure
__ Other ________________________________

__ Skin sensitivity
__ Claustrophobia

Due to the history and diagnosis noted 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: ____________

NPI:____

Signature: ____ Date: _____________

Please call for an appointment (734) 425-4400 Appointment Date: _______ Time: _________

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