EARL K. BOGROW DDS, FAGD

Diplomate-American Board of Dental Sleep Medicine

Dental Center for Sleep Apnea & Snoring

Something to SMILE about...
a good night's SLEEP

Referral For Oral Appliance Therapy

Patient: ______________________________ DOB: ______________________________

Address: ______________________________ HT: ______________ WT: ______________

______________________________ Sleep Study Date: ______________________________

Telephone: Home ______________________________ AHI: ______________ RDI: ______________

Cell: ______________________________ CPAP Pressure: ______________________________

______ **Please provide copy of baseline sleep study, clinic notes prior to sleep study, (why study needed), and this signed referral form.**

Diagnosis (please check)

______ Obstructive sleep apnea

______ Upper airway resistance syndrome

______ Narcolepsy

______ Periodic limb movement disorder

______ Restless leg syndrome

Treatment Orders (please check)

______ Mandibular Advancement Device for treatment of OSA

______ Mandibular Advancement Device to be used in combination witth CPAP

______ Positional Therapy (positional cushion to prevent supline sleep)

______ Other

Medical Justification (Patient has tried CPAP and has not tolerated and/or complied with treatment of the following reasons):

______ Unable to tolerate mask/straps

______ Unable to tolerate effective CPAP pressure

______ 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: ______________________ Phone: ______________ NPI: ______________

Signature: ____ Date: ______________

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Please call to schedule an appointment