Bogrow & Associates

Dental Center for Sleep Apnea & Snoring
Earl K. Bogrow, DDS, FAGD, D-ABDSM
www.bogrowandassociates.com

Referral For Oral Appliance Therapy

Patient: _____ DOB: _____
Address: _____ HT: _____ Wt: _____
_____ Sleep Study Date: _____
Telephone: Home: _____ AHI: _____ RDI: _____
Cell: _____ CPAP Pressure: _____

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 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
_____ 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