

Oral Appliance Referral Form For Medically Diagnosed Obstructive Sleep Apnea

Patient's Information

Full Name: _____
Last
First
M.I.

Address: _____
Street Address
Apartment/Unit #

_____ *City* *State* *ZIP Code*

Home Phone: () _____ DOB: _____ E-mail: _____

Requesting Physician's name: _____ Physician's Email: _____

Medical Insurance information: _____
 Insurance Provider: HMO PPO POS EPO Indem MCR MCD

Policy Number: _____ Group Number: _____ Employer: _____

Insured: Self Spouse Child Other

Sleep Study Available: Yes _____ No _____ Medicare: Yes No

Reason For Referral (Mark All That Apply)

Diagnosis:

- | | | |
|--|---|---|
| <input type="checkbox"/> Obstructive Sleep Apnea (ICD 327.23) | <input type="checkbox"/> Insomnia due to Sleep Apnea (ICD 780.51) | <input type="checkbox"/> Sleep Apnea/Sleep Related Breathing Disorder, Unspecified (ICD 327.20) |
| <input type="checkbox"/> Hypersomnia due to Sleep Apnea (ICD 780.53) | <input type="checkbox"/> Other, Unspecified (ICD 780.57) | |

Without Appliance (CPAP Or Oral Appliance):

Respiratory Disturbance Index (RDI) _____ Lowest Desaturation (SpO2) _____
 Apnea Hypopnea Index (AHI) _____ Percentage or Amount of Time Below 90% _____

Therapies Attempted:

CPAP: Intolerant Not a good candidate
 Surgery: Yes No

Other _____

Successful CPAP Pressure: _____

Comments/ Special Concerns: _____

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's Signature: _____ Date: _____

Thank you for your referral. If you have any questions please contact Bailey Horn at 800-667-3753 or email at bailey@SleepDallas.com