Frisco – 7589 Preston Rd. #400 Irving – 290 E. John Carpenter Frwy. #2700 Tel: 844-409-4657 F: 214-614-4277 Email: info@sleepdallas.com

Oral Appliance Referral Form For Treatment of Snoring or 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 Provider's name: ____________________ MD'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, if any:

☐ Obstructive Sleep Apnea (ICD 327.23)

☐ Insomnia due to Sleep Apnea (ICD 780.51)

☐ Sleep Apnea/Sleep Related Breathing Disorder, Unspecified (ICD 327.20)

☐ Hypersomnia due to Sleep Apnea(ICD 780.53)

☐ Other, Unspecified (ICD 780.57)

Sleep Study Data (if available) Without Appliance (CPAP Or Oral Appliance):

Respiratory Disturbance Index (RDI)__________________

Lowest Desaturation (SpO2) ______________ ODI __________________

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

I am requesting that Dr. Smith evaluate my patient and treat, if medically necessary.

Provider's Signature: ____________________ Date: ____________________

Thank you for your referral. If you have any questions please contact Bailey Horn at 844-409-4657 or email at Bailey@SleepDallas.com