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ORAL APPLIANCE THERAPY REFERRAL FORM

Date:_____

PATIENT: _____

REFERRED BY:_____

APPOINTMENT TIME AND DATE:_____

SLEEP DISORDER:

Sleep Apnea:

None _____

Mild _____

Moderate _____

Severe _____

Snoring:

Intensity: _____

Frequency: _____

DATE OF SLEEP TEST: _____

COPY OF SLEEP TEST: Attached_____

Faxed _____

Special Comments and instructions:

_____

_____

_____

SIGNATURE OF REFERRING DR.