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Referral Prescription for Oral Appliance Therapy

Please evaluate _____, _____ for
(print patient name) (patient phone number)
treatment with oral appliances due to the following:

- CPAP intolerant
- Inadequate surgical result
- Primary snoring
- Mild or moderate OSA
- Adjunct to CPAP or surgery

Comments: _____

This patient has a polysomnogram available. Yes No

Please fax polysomnogram and report to:

Physician name _____ (please print)

Physician phone number _____

Physician signature _____ Date _____

Courtesy of:

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