Referral Prescription for Oral Appliance Therapy

Practice limited to dental sleep medicine

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

[ ] CPAP intolerance

[ ] Positive medical history: snoring, sleepiness, observed apnea

[ ] Positive clinical findings: obstructed upper airway, large neck size obesity, high blood pressure

[ ] Inadequate surgical results

Comments: ____

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Pending dental work: ____

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Dentist name ____________________________________ (please print)

Dentist phone number _____________________________

Dentist signature ____________________________________ Date _____________

Please note that no restorative services will be rendered. In addition, you will be continually updated on the progress of the oral appliance therapy.

Courtesy of:
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