

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: _____

Pending dental work: _____

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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