SLEEP BETTER DENTAL MEDICINE
OF THE MAIN LINE

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Recommendation for Oral Appliance Therapy

To: Amy Shoumer, DMD, ABDSM Qualified

Oral Appliance Referral For:

Patient:_____ DOB: _____

_____ Sleep Study Date:_____

City, State, Zip:_____ AHI:_____ RDI:_____

Telephone: (H): _____ CPAP Pressure:_____

(C):_____

Diagnosis (please check)

_____ Obstructive Sleep Apnea
_____ Upper Airway Resistance Symptoms
_____ Narcolepsy
_____Periodic Limb Movement Disorder
_____Restless Leg Syndrome
_____Primary Snoring

Treatment Orders (please check)

_____ Mandibular Advancement Device for treatment of OSA
_____ Mandibular Advancement Device to be used in combination with CPAP
_____ Mandibular Advancement Device to be used for treatment of primary snoring
_____ Other

Medical Justification (Patient has tried CPAP and has not tolerated and/or complied with treatment for the following reasons):

_____Unable to tolerate mask/straps
_____Unable to tolerate effective CPAP pressure
_____ N/A
_____Skin Sensitivity
_____ Claustrophobia
_____ Other Continuation of Care

Due to the history and diagnosis above, I am recommending oral appliance therapy for the treatment of this patient. I, the undersigned, certify the procedure prescribed above is medically necessary for the treatment of this sleep disorder. I understand the oral appliance will be needed for an indefinite period of time.

Referring Physician :_____(print) Phone:_____

Signature:_____ Date:_____

NPI#:_____