

REFERRAL FOR ORAL APPLIANCE THERAPY TO TREAT  
SLEEP DISORDERED BREATHING

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Date: \_\_\_\_\_

Patient: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Is patient intolerant of CPAP?      Yes \_\_\_\_\_      No \_\_\_\_\_

Please mail or fax a copy of the patient's sleep study

The above patient is being referred for a medically necessary oral appliance to control  
 snoring                               obstructive sleep apnea.

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(signature of referring Physician)

Please mail or fax this form to us as soon as possible so we have permission to begin treatment for this patient. Thank you.

\*Diplomate of the American Board of Dental Sleep Medicine