Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea (OSA)

Referring Phyician:______________________________ Tel:______________________

Patient Name:______________________________ Date of Birth:______________________

Patient Address:____

Patient Telephone:____

Please fax copy of patient's medical insurance card with this prescription.

The patient referred with this form has been evaluated by the above physician and has been diagnosed using acceptable medical criteria to have:

○ Obstructive Sleep Apnea Or ○ Simple Snoring Severity______________________

This patient is:

○ Intolerant of C-PAP therapy ○ Not a candidate for C-PAP therapy

Explanation (if necessary)____

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Notes:____

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Signature of Referring Physician:____

Date:______________________ *As a physician, I deem this therapy to be medically necessary.*

Please fill out this prescription in its entirety.

*Obstructive Sleep Apnea is a medical condition that tends to become more severe with time and requires periodic re-evaluation by a qualified physician.