sleep
NASHVILLE

RX for Oral Appliance Therapy
for Medically Diagnosed Obstructive Sleep Apnea

Patient Name: _____ DOB: _____

Date of PSG or HST: _____ AHI/RDI: _____

The patient referred has been evaluated by the physician listed below and has been diagnosed with the following:

- ☐ Primary Snoring (R06.83)
- ☐ Obstructive Sleep Apnea (G47.33)
- ☐ Other: _____ (_____)

This patient:

- ☐ Is intolerant to positive airway pressure (PAP) treatment.
- ☐ Is not a candidate for positive airway pressure (PAP) treatment
- ☐ Has decided, after all options have been discussed, they would like to proceed with oral appliance therapy as their initial treatment.
- ☐ Requires combination treatment of an oral appliance and CPAP therapy.
- ☐ Other: _____

_____

Thank you,

_____ Date: _____

Physician Signature

* I have attached:

- ☐ Patient's Demographics
- ☐ Copy of Patient's Sleep Study
- ☐ Patient's Insurance Information

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