AMELIA GENTLE DENTISTRY | QUICK SLEEP REFERRAL

Refer for Oral Appliance Therapy

Fax this page with the sleep study and relevant clinical note, if available.

PATIENT INFORMATION

Patient name: _____

DOB: _____ **Patient phone:** _____

Patient email: _____

REASON FOR REFERRAL

☐ Evaluate for oral appliance therapy ☐ CPAP intolerance/nonadherence ☐ Patient prefers OAT

☐ Primary snoring (OSA excluded)

Other: _____

SLEEP DIAGNOSIS / TESTING

☐ OSA **Severity:** ☐ Mild ☐ Moderate ☐ Severe

Sleep study date: _____

☐ HSAT ☐ PSG ☐ Copy attached

Current/previous PAP: ☐ Yes ☐ No **Notes:** _____

REFERRING CLINICIAN

Name / credentials: _____

Practice: _____

Phone: _____ **Fax:** _____

Signature: _____ **Date:** _____

SEND REFERRALS TO

Dedicated Sleep Fax: (904) 85-SLEEP / (904) 857-5337

Amelia Gentle Dentistry | 1699 S 14th St #21, Fernandina Beach, FL 32034 | (904) 277-8500

A physician or other qualified treating practitioner should diagnose OSA and prescribe/coordinate treatment. Medicare coverage for a custom mandibular advancement device has specific evaluation, sleep-test, and documentation criteria.