REFERRAL

TO: ❒ Dr. David Schram, DDS ❒ Dr. Blake Smith, DDS

Patient Information:

Patient ______________________________ DOB ______________________________

Address ______________________________ Telephone # (H)______________________________

______________________________ (C)______________________________

Treatment Orders: *(Please check)*

❒ Home Sleep Test
❒ Mandibular Advancement Device for Snoring
❒ Mandibular Advancement Device for treatment of OSA
❒ Mandibular Advancement Device to be used in combination with CPAP

❒ Other ______________________________

Sleep Test Results: *(If previously evaluated)*

Sleep Study Date ______________________________ AHA ______________________________

CPAP Pressure______________________________ RDI ______________________________

Diagnosis: (If applicable, please check)

❒ Obstructive Sleep Apnea
❒ Upper Airway Resistance Syndrome
❒ Simple Snoring
❒ Periodic Limb Movement Disorder
❒ Restless Leg Syndrome

Medical Justification: *(If applicable)* 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
❒ Skin sensitivity
❒ Claustrophobia

❒ Other ______________________________

Referring Physician: *Please download, sign and return to us by fax or email.*

Referring Physician: ______________________________ Phone: ______________________________

Referring Physician Signature:______________________________Date: ______________________________

If referring for a sleep appliance, please also fill out the separate Rx form.

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