Rx

FOR ORAL APPLIANCE THERAPY

Physician: _____ Telephone: _____

Office Address _____

Patient Name: _____ DOB _____

Patient Address: _____

Patient Telephone: _____

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

☐ Obstructive Sleep Apnea ☐ Simple Snoring (Severity: _____)

This patient is:

☐ Intolerant of CPAP therapy
☐ Not a candidate for CPAP Therapy
☐ Intolerant of and prefers Oral Appliance Therapy

Explanation (if necessary): _____

The patient is being sent for OA therapy with:

☐ The appliance chosen by the dentist and the patient as most suitable
☐ A _____ appliance *(specify)*

Explanation (if necessary): _____

Please download, sign and return to us by fax or email.

Physician Signature: _____

As a physician, I deem this therapy to be medically necessary.

Date: _____

Obstructive Sleep Apnea is a medical condition which tends to become more severe with time and requires periodic re-evaluation by a qualified physician. Oral Appliance Therapy is less effective in controlling this disease than a CPAP, and patients referred for this therapy may need to explore additional options for treatment if the appliance alone is deemed to provide suboptimal management of the sleep apnea.

Better Sleep Bemidji

2600 Bemidji Ave. N · Bemidji, MN 56601 · 218-444-4991 (Ph) · 218-751 4462 (Fax)
snooze@bettersleepbemidji.com · bettersleepbemidji.com