Dental Sleep Medicine Referral Form

Phone: (866) 801-9440
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Dental Practice Name:

Date of Referral:

Section 1: Patient Information (required)

Patient Name:

Address, City, State, Zip:

Date of Birth:

Home Phone:

Cell Phone:

Email:

Referring Physician:

Address, City, State, Zip:

Phone:

Fax:

Email:

National Provider Identifier:

Section 2: Symptoms & Reason For Referral (Please attach recent consult notes)

- ☐ Stroke
- ☐ Diabetes
- ☐ Cardiac Disease
- ☐ COPD
- ☐ Hypertension
- ☐ Obesity
- ☐ Mood Disorder
- ☐ History of OSA (G47.33)
- ☐ Snoring
- ☐ Excessive Daytime Sleepiness
- ☐ CPAP Intolerant
- ☐ CPAP Refusal

Section 3: Sleep Disorders Services (required)

- ☐ Please initiate oral appliance therapy for OSA. (E0485, E0486, 99203, 99213, 70486)
- ☐ Please evaluate current oral appliance for adjustments or repairs. (L4204, L4210)
- ☐ Oral appliance replacement (E0486)
- ☐ Initiate treatment of Temporal Mandibular Joint disorder with Occlusal Orthotic Device. (D7880)

Practitioner Signature:

Special Requests:

Date:

Patient Insurer Name and Insurance ID#: