Sleep IMPRESSIONS
an apnome company

ORAL APPLIANCE THERAPY ORDER FORM FAX to: 888.834.8786

Patient Demographics:

Name:_____ ☐M ☐F DOB:__/__/____ SS#:___-___-____

Address:_____ City:_____ State:_____ Zip:_____

Home phone #:_____ Cell phone #:_____

Signs and Symptoms: *Please check all that apply*

- ☐ **Excessive daytime sleepiness (ESS) evidenced by** ESS > 10, *or* daytime napping, *or* interfere with daily activities
- ☐ **Hypertension**
- ☐ **Heart Disease**
- ☐ **Diabetes**
- ☐ **Obesity with a BMI > 30**
- ☐ **Mood Disorders**
- ☐ **CPAP Intolerance or Non-compliance**
- ☐ **CPAP Refusal**

ATTACH COPIES OF:

- ☐ **Sleep Study Results**
- ☐ **Applicable Office Notes**
- ☐ **Front and Back of Primary and Secondary Insurance Cards**

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Treatment Ordered: Oral Appliance Therapy, including mandibular advancement device, realignment appliance, and referral for consult and follow-up

Diagnosis: G47.33 Obstructive Sleep Apnea confirmed by sleep study

Treatment Plan: Options were discussed with patient and oral appliance was agreed upon

Referring Physician Demographics:

Physician Name:_____ UPIN: _____ NPI: _____

Address: _____ City:_____ State:_____ Zip: _____

Phone: _____ Fax:_____

Due to the potentially dangerous consequences of disturbed sleep and sleep deprivation, which include the possibility of falling asleep in critical situations, and the patient's intolerance or refusal of CPAP, Oral Appliance treatment is considered necessary rather than elective for a long term to lifetime duration.

Physician Signature:_____ Date: _____

I am the patients treating physician and I have ordered this prescription based upon office visit.

Phone: (877) 933-9470