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DIPLOMATE, AMERICAN BOARD OF PROSTHODONTICS

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ORAL APPLIANCE ORDER FORM

FAX TO: (352)596-4162

Patient:

Address:

Telephone: H
 W/Cell

DOB:

Height:

Weight:

Sleep Study Date:

CPAP Pressure:

Diagnosis: (please check)

Obstructive Sleep Apnea

Restless Leg Syndrome

Other:

Periodic Limb Movement

Reactive Airway Disease

ORDERS:

Mandibular Advancing Device (Oral Appliance for treatment of OSA)

Other:

MEDICAL JUSTIFICATION: Patient has attempted CPAP and has not complied for the following reason(s):

Unable to tolerate Mask/Straps

High CPAP pressure. Patient may benefit from appliance or combination appliance/CPAP therapy

Other

Due to the above noted history and physical information I am recommending an Oral Appliance for treatment of this patient. I, the undersigned, certify the above prescribed procedure is medically necessary in the treatment of this diagnosis.

Referring Physician:

Phone:

Fax:

Signature:

Date: