CPAP Alternatives • Snoring • TMJ Pain

SLEEP SOLUTIONS NORTHWEST

REFERRAL FOR CUSTOM MANDIBULAR ADVANCEMENT DEVICE

Patient Name:____ Date of Birth:_______________

Phone(s): Cell___________________ Work_____________________ Date of Referral:_______________

Patient was screened, and displays the following risk factors for Obstructive Sleep Apnea:

___Class II ___Excess OB/OJ ___Bruxism ___Scalloped tongue ___On 2+ BP meds ___Obese ___Unrefreshing Sleep

___Patient has a restorative or periodontal treatment plan that must be completed before impressions for MAD.

___Patient has AT LEAST 10 stable teeth on both the upper and lower arches.

Comorbid health conditions present on Health History: Will assist in obtaining medical insurance coverage:

___Hx. CVA ___Hx. Heart Disease ___High BP ___Insomnia ___Foggy Thinking ___Mood Disorders/Depression

Status of Obstructive Sleep Apnea Diagnosis and Prior Treatment attempts:

___Patient has NOT been diagnosed with OSA by a medical provider. Please refer to a sleep physician for sleep study.

___Patient HAS been diagnosed with OSA previously, but is unable or unwilling to wear a CPAP device.

Notes:____

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Referring Dental Practice:_______________________________________ Email:_______________________

FAX:_________________________ Direct Phone:_________________________ Contact_________________

Provider Office Address:____

Provider's Signature:____

PLEASE SEND MORE OF THE FOLLOWING: ___Brochures on Mandibular Advancement Devices ___Referral Slips

DDS REF OSA 5.21.19

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Stuart Rich, DDS, PS
DABDSM, DABCDSM, DACSDD
P 253.236.5240 F 866.861.6286
E info@SleepSolutionsNW.com www.SleepSolutionsNW.com
4798 Auburn Way N, Suite 106, Auburn, Washington 98002-1501