SLEEP BETTER DENTAL MEDICINE
OF THE MAIN LINE

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**Recommendation for Oral Appliance Therapy**

**To: Amy Shoumer, DMD, ABDSM Qualified**

**Oral Appliance Referral For:**

Patient:_____ DOB: _____

_____ Sleep Study Date:_____

City, State, Zip:_____ AHI:_____ RDI:_____

Telephone: (H): _____ CPAP Pressure:_____

(C):_____

**Diagnosis (please check)**

_____ Obstructive Sleep Apnea
_____ Upper Airway Resistance Symptoms
_____ Narcolepsy
_____Periodic Limb Movement Disorder
_____Restless Leg Syndrome
_____Primary Snoring

**Treatment Orders (please check)**

_____ Mandibular Advancement Device for treatment of OSA
_____ Mandibular Advancement Device to be used in combination with CPAP
_____ Mandibular Advancement Device to be used for treatment of primary snoring
_____ Other

**Medical Justification (Patient has tried CPAP and has not tolerated and/or complied with treatment for the following reasons):**

_____Unable to tolerate mask/straps
_____Unable to tolerate effective CPAP pressure
_____ N/A
_____Skin Sensitivity
_____ Claustrophobia
_____ Other Continuation of Care

Due to the history and diagnosis above, I am recommending oral appliance therapy for the treatment of this patient. I, the undersigned, certify the procedure prescribed above is medically necessary for the treatment of this sleep disorder. I understand the oral appliance will be needed for an indefinite period of time.

Referring Physician :_____(print) Phone:_____

Signature:_____ Date:_____

NPI#:_____