Patient:____

DOB: _____/________/______   Phone: (____) __________

Diagnosis: (please check)

___ Snorer

___ Insomnia

___ Restless Leg Syndrome

___ Obstructive Sleep Apnea

___ Upper Airway Resistance Syndrome

___ Failed Upper Airway Surgery

___ Fibromyalgia

___ Narcolepsy

___ Other________________________

Medical Necessity: Patient has attempted CPAP and has not complied for the following reason(s):

___ Unable to tolerate mask

___ High CPAP pressure

___ Chronic sinusitis

___ Dermatitis

___ Patient may benefit from combination: CPAP & OAT

___ Other_______________

Referral For

___ ***OAT*** For the treatment of OSA/UARS/Snoring

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

Referring Physician: ______________________   Phone: _____________

Signature: ______________________________   Date: ______________