Schell Family Dental Care

dentistry with a gentle touch

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Oral Appliance Referral Form

for

Medically Diagnosed Obstructive Sleep Apnea

Patient: **Patient Address:**

Date of Birth: **Patient Phone:**

Diagnosis:

___ Obstructive sleep apnea – ICD 327.23
___ Insomnia due to Sleep Apnea ICD 780.51
___ Narcolepsy
___ Hypersomnia due to Sleep Apnea - ICD 780.53
___ Sleep Apnea, Other, Unspecified – ICD 780.57
___ Restless leg syndrome
___ Sleep Apnea/Sleep Related Breathing Disorder, Unspecified - ICD 327.20 (UARS)

Without Appliance

Respiratory Disturbance Index (RDI):__________
Apnea Hyponea Index (AHI):__________
Lowest Desaturation (SpO2):__________
% of Time below 90%:__________

With Appliance

Respiratory Disturbance Index (RDI):__________
Apnea Hyponea Index (AHI):__________
Lowest Desaturation (SpO2):__________
% of Time below 90%:__________

Treatment Orders:

___ Mandibular Advancement Device for treatment of OSA
___ Mandibular Advancement Device to be used in combination with CPAP
___ Positional Therapy (positional cushion to prevent supine sleep)
____Sleep Study- attended (CPT 95807)

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
___ Other________________________________
___ Skin sensitivity
___ Claustrophobia

Statement of Medical Necessity

Due to the history and diagnosis noted 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.

Oral Appliance Therapy is used as an alternative to surgery as this time and/or CPAP, as this patient could not tolerate CPAP.

Referring Physician:_____________________________(printed) Phone:______________

Physician's Signature:___________________________ Date:_______________