Oral Appliance Referral Form for the Treatment of Obstructive Sleep Apnea

Patient's Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: (____) _____ DOB:_____ E-mail: _____

Requesting Physician's name: _____ Physician's Email: _____

Medical Insurance information:

Insurance Provider: HMO PPO POS EPO Indem MCR MCD

Policy Number: Group Number: Employer:

Insured: Self ☐ Spouse ☐ Child ☐ Other ☐

Sleep Study Available: Yes_____ No_____ Medicare: ☐ Yes ☐ No

Reason For Referral (Mark All That Apply)

Diagnosis:

☐ Obstructive Sleep Apnea (ICD 327.23)
☐ Insomnia due to Sleep Apnea (ICD 780.51)
☐ Sleep Apnea/Sleep Related Breathing Disorder, Unspecified (ICD 327.20)
☐ Hypersomnia due to Sleep Apnea(ICD 780.53)
☐ Other, Unspecified (ICD 780.57)

Sleep Study Data (if available) Without Appliance (CPAP Or Oral Appliance):

Respiratory Disturbance Index (RDI)_____
Apnea Hypopnea Index (AHI) _____
Lowest Desaturation (SpO2) _____
Percentage or Amount of Time Below 90% _____

Therapies Attempted:

CPAP: ☐ Intolerant ☐ Not a good candidate
Surgery: ☐ Yes ☐ No
Other _____
Successful CPAP Pressure: _____
Comments/ Special Concerns:_____

Statement of Medical Necessity

I am requesting that Asia Pacific Dental/Dr Kelvin Chye evaluate my patient and treat, if medically necessary.

Dentist's Signature:_____ Date: _____