Texas Sleep Solutions

# 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)_____
Lowest Desaturation (SpO2) _____
Apnea Hypopnea Index (AHI) _____
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 Texas Sleep Solutions evaluate my patient and treat, if medically necessary.

Dentist's Signature: _____ Date: _____