Texas Sleep Solutions

Oral Appliance Referral Form for Medically Diagnosed 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)

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

This above patient has undergone a sleep study for a sleep related breathing disorder. This evaluation confirmed the diagnosis of obstructive sleep apnea. This evaluation confirmed that an Oral Appliance is medically necessary. Oral Appliance Therapy is used as an alternative to surgery at this time and or CPAP, as this patient could not tolerate CPAP or does not feel he/she will be able to tolerate CPAP.

Physician's Signature: _____ Date: _____