REFERRAL FORM FOR ORAL APPLIANCE TREATMENT

DENTAL PROVIDER

Practice:
Dr:
Address:

Fax:
Email:
Phone:

Practice:
Dr:
Address:

Fax:
Email:
Phone:

PATIENT DETAILS

Name:
Address:

Postcode:

DOB:
Gender: ☐ M ☐ F
Email:
Phone:

CLINICAL DETAILS

PLEASE ATTACH SLEEP STUDY RESULTS TO THIS REFERRAL

- ☐ Primary snoring
- ☐ Mild Obstructive Sleep Apnoea
- ☐ Moderate Obstructive Sleep Apnoea
- ☐ Severe Obstructive Sleep Apnoea
- ☐ Nasal congestion/obstruction
- ☐ Prefers alternative to CPAP
- ☐ Unable to tolerate CPAP
- ☐ Refused or non-compliant with CPAP

Other comments:

TREATMENT ORDER

I AM RECOMMENDING ORAL APPLIANCE THERAPY FOR THE TREATMENT OF THIS PATIENT.
PLEASE REVIEW DENTAL SUITABILITY AND KEEP ME INFORMED OF PROGRESS.

- ☐ Mandibular Advancement Device as primary treatment
- ☐ Mandibular Advancement Device as short term CPAP alternative
- ☐ Mandibular Advancement Device to be used in combination with CPAP

REFERRING PHYSICIAN

Name:
Address:

Phone:

Email:
Provider No.:
Signed:
Date:

Provider Name: