Sleep Apnea
& TMJ Therapy
of Southern New England

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Physician Recommendation for Oral Appliance Therapy

To: Dr. Robert S. Semco

Oral Appliance Referral for:

Patient Name: _____ DOB: _____

Address: _____ Ht: _____ Wt: _____

_____ Sleep Study Date: _____

City, State, Zip: _____ AHI: _____ RDI: _____

Telephone: (Home) _____ CPAP Pressure: _____

(Cell) _____

Diagnosis (please check)

- ☐ Obstructive Sleep Apnea ☐ Primary Snoring
- ☐ Other: _____

Treatment Orders (please check)

- ☐ Mandibular Advancement Device for treatment of OSA
- ☐ Mandibular Advancement Device for treatment of primary snoring
- ☐ Mandibular Advancement Device to be used in combination with CPAP
- ☐ Other: _____

Medical Justification

(Patient has tried CPAP and has not tolerated and/or complied with treatment for the following reasons):

- ☐ Unable to tolerate mask/straps ☐ Skin sensitivity
- ☐ Unable to tolerate effective CPAP pressure ☐ Claustrophobia
- ☐ Other: _____

Due to history and diagnosis 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. I understand the oral appliance will be needed for an indefinite period of time.

Referring Physician: _____ Phone: _____
(please print)

Date: _____

Signature: _____ NPI#: _____