Prescription For Oral Appliance Therapy for Obstructive Sleep Apnea*

Physician: _____NPI:_____
Office Address:_____

Patient Name: _____ DOB:_____
Patient Address: _____
Patient Telephone: _____

Prescription to be filled by:

Sleep Apnea Dentists of New England
70 Wells Ave. Suite 103
Newton, MA 02459
Phone: 617-964-4028 Fax: 617-595-4591
Email: Office@SleepApneaDentist.com

The patient referred with this form has been evaluated by the above physician and has been diagnosed, using acceptable medical criteria, to have:

□ Obstructive sleep apnea or Severity_____
□ Simple Snoring.

This patient is:

□ Intolerant of CPAP therapy
□ Is not a candidate for CPAP therapy
Explanation (if necessary):

_____
_____

The patient is being sent for OA therapy with:

□ The appliance chosen by Dr Cohn and the patient as most suitable
□ A_____appliance (specific name)

By signing below, I attest that this is my signature. _____
Print Name

_____
Signature of referring physician:*

***As a physician, I deem this therapy to be medically necessary.**

Date:_____

Obstructive Sleep Apnea is a medical condition that tends to become more severe with time, and requires periodic re-evaluation by a qualified physician.
Oral Appliance Therapy is less effective in controlling this disease than CPAP, and patients referred for this therapy may need to explore additional options of treatment if the appliance alone is deemed to provide suboptimal management of the sleep apnea.
Copies of diagnostic Sleep Studies with full report are required for appropriate care and to obtain medical insurance coverage.

Original Prescription MUST be mailed or faxed to Sleep Apnea Dentists