Angellift Dental Center

Dr. Jim Hales DDS

781 NE 7th Street Suite B Grants Pass OR 97526

Telephone: 541-474-1100 Fax: 541-474-1103

Member: AADSM

www.angelliftdental.com

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: _____ Email: _____

Requesting Physician's Name: _____ Email: _____

Insurance Provider: _____HMO_____PPO_____POS_____EPO_____INDEM_____MCR_____MCD_____

Policy Number:_____ Group Number: _____ Employer: _____

Insured: Self ☐ Spouse ☐ Child ☐ Other ☐ Medicare: YES ☐ NO ☐

Sleep Study Available: YES ☐ NO ☐

Reason For Referral (Mark All That Apply)

Diagnosis: ☐ **Obstructive Sleep Apnea (ICD G47.33)** ☐ Insomnia due to Sleep Apnea (ICD G47.30)

☐ Sleep Apnea/Sleep Related Breathing Disorder, Unspecified (ICD G47.30) ☐ Hypersomnia due to Sleep Apnea (ICD G47.30)

☐ Other, Unspecified (ICD G47.30)

Rx: ☐ **Fabricate Custom Oral Appliance**

Without Appliance (CPAP) or Oral Appliance):

Respiratory Disturbance Index (RDI) _____ Lowest Desaturation (SpO2) _____

Apnea Hypopnea Index (AHI) _____ Percentage of Time Below 90% _____

Therapies Attempted: CPAP: Intolerant ☐ Not a good Candidate ☐ Surgery: YES ☐ NO ☐

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 at an Oral Appliance is medically necessary. Oral Appliance Therapy (OAT) is used a 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: _____