Terrance L. Smith, DDS, FACP
Diplomate American Board of Prosthodontics
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Member: American Academy of Dental Sleep Medicine

Southeastern Dental
TMD & Sleep Medicine Center
SMITH & ASSOCIATES

Oral Appliance Referral

Patient _____ DOB _____

Address _____

_____ Sleep Study Date _____

Phone (H) _____ AHI _____ RDI _____

(C) _____ CPAP Pressure _____

Diagnosis

☐ Obstructive Sleep Apnea ☐ Upper Airway Resistance Syndrome ☐ Other_____

Treatment Orders

☐ Mandibular Advancement Device for treatment of OSA

☐ Mandibular Advancement Device to be used in combination with CPAP

☐ Other_____

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

☐ Unable to tolerate mask/straps ☐ Skin Sensitivity ☐ Non-compliance with CPAP wear

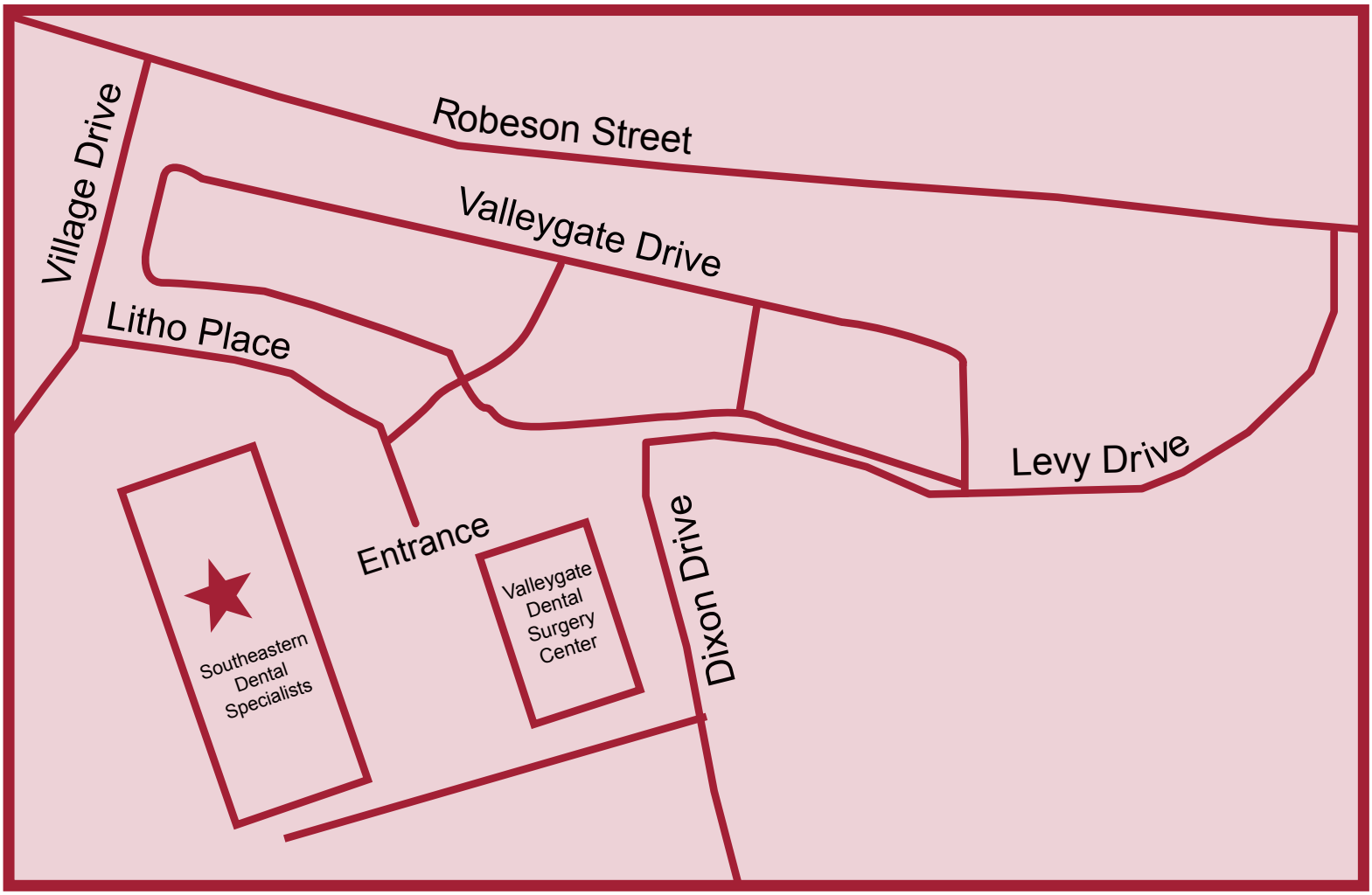
☐ Unable to tolerate effective CPAP pressure ☐ Claustrophobia ☐ Other_____

Due to the 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:

Referring Physician _____ Phone _____

Signature _____ Date _____

Please call (910) 635-7653 for an appointment or fax form to (910) 446-8183 Appt. Date _____



Southeastern Dental TMD & Sleep Medicine Center

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Please ask for the Sleep Coordinator