Metro Dental Sleep Medicine

Referral for Oral Appliance Therapy
To:
Saba S. Khalil, DMD **Gilbert R. Hart, DMD**

Oral Appliance Referral for:

Fax: (314) 675-9955

Patient: _____ DOB: _____

Address: _____ Needs Sleep Study_____

_____ Sleep Study Date: _____

Telephone: (H)_____ Ht: _____

(C) _____ AHI: _____ RDI: _____

CPAP Pressure: _____

Diagnosis (please check)

_____ Obstructive Sleep Apnea
_____ Upper Airway Resistance Syndrome
_____ Narcolepsy
_____ Periodic Limb Movement Disorder
_____ Restless Leg Syndrome
_____ Other _____

Treatment Orders (please check)

_____ Mandibular Advancement Device for treatment of OSA
_____ Mandibular Advancement Devide 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
_____ Unable to tolerate effective CPAP pressure
_____ Other _____
_____ Skin sensitivity
_____ Claustrophobia

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: _____(print) Phone: _____

Signature: _____ Date: _____

Please call for an appointment (314) 849-5555 • Toll Free 855-2SLEEP-EZ

Appointment Date: _____ **Time:** _____

METRO DENTAL SLEEP MEDICINE - Snoring and Sleep Apnea Dental Treatment
Saba S. Khalil, DMD • Gilbert R. Hart, DMD
11222 Tesson Ferry Road, Suite 203 • Saint Louis, Missouri 63123
P(314) 849-5555 • 855-2SLEEP-EZ • F(314) 675-9955
info@StLDentalStopSnoring • www.StLDentalStopSnoring.com

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ADDITIONAL INSTRUCTIONS/COMMENTS