# Sleep Apnea Boston by Congress Dental Group

# Congress Dental Group

# 160 Federal St, Floor 1, Boston, MA 02110

# Phone: 617-574-8700

# 

Oral Appliance Referral Form for patients diagnosed with OSA

Patient’s full name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_E-MAIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requesting Physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_FAX\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sleep Study Available: YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicare: YES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_NO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for referral (Mark all that apply)

Diagnosis:

* Obstructive Sleep Apnea (ICD 327.23)
* Hypersomnia due to Sleep Apnea (ICD 780.53)
* Insomnia due to Sleep Apnea ( ICD 780.51)
* Other , unspecified (ICD 780.57)

Baseline Data (without CPAP or Oral Appliance)

AHI\_\_\_\_\_\_\_\_\_\_\_\_\_\_RDI\_\_\_\_\_\_\_\_\_\_\_\_\_\_Lowest Desaturation (SpO2)\_\_\_\_\_\_\_\_\_\_\_\_T90 \_\_\_\_\_\_\_\_

Therapies attempted:

* CPAP Intolerant \_\_\_\_\_\_\_\_ Not a good candidate\_\_\_\_\_\_\_\_
* Oral Appliance (Mandibular Advancement Device) chosen as first line of therapy\_\_\_\_\_\_\_\_
* Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Statement of Medical Necessity and Rx:

The above patient has undergone a sleep study for a sleep related breathing disorder. This evaluation confirmed the diagnosis of obstructive sleep apnea. I am prescribing a FDA approved Mandibular Advancement Device (EO486) for this patient. Oral Appliance Therapy is used as an alternative to PAP and/or surgery.

Physician Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_