



Oral Appliance Referral Form
for
Medically Diagnosed Obstructive Sleep Apnea

Patient:

Patient Address:

Date of Birth:

Patient Phone:

Diagnosis:

- | | |
|--|---|
| <input type="checkbox"/> Obstructive sleep apnea – ICD 327.23 | <input type="checkbox"/> Hypersomnia due to Sleep Apnea - ICD 780.53 |
| <input type="checkbox"/> Insomnia due to Sleep Apnea ICD 780.51 | <input type="checkbox"/> Sleep Apnea, Other, Unspecified – ICD 780.57 |
| <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Restless leg syndrome |
| <input type="checkbox"/> Sleep Apnea/Sleep Related Breathing Disorder, Unspecified - ICD 327.20 (UARS) | |

Without Appliance

Respiratory Disturbance Index (RDI): _____
Apnea Hyponea Index (AHI): _____
Lowest Desaturation (SpO2): _____
% of Time below 90%: _____

With Appliance

Respiratory Disturbance Index (RDI): _____
Apnea Hyponea Index (AHI): _____
Lowest Desaturation (SpO2): _____
% of Time below 90%: _____

Treatment Orders:

- Mandibular Advancement Device for treatment of OSA
- Mandibular Advancement Device to be used in combination with CPAP
- Positional Therapy (positional cushion to prevent supine sleep)
- Sleep Study- attended (CPT 95807)

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

- | | |
|---|---|
| <input type="checkbox"/> Unable to tolerate mask/straps | <input type="checkbox"/> Skin sensitivity |
| <input type="checkbox"/> Unable to tolerate effective CPAP pressure | <input type="checkbox"/> Claustrophobia |
| <input type="checkbox"/> Other _____ | |

Statement of Medical Necessity

Due to the history and diagnosis noted 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.

Oral Appliance Therapy is used as an alternative to surgery as this time and/or CPAP, as this patient could not tolerate CPAP.

Referring Physician: _____ (printed) Phone: _____

Physician's Signature: _____ Date: _____