MD Prescription Referral for OAT (Oral Appliance Therapy)

SLEEP SOLUTION CENTERS
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Patient Name: _____ DOB: _____ Phone:_____Date:_____

This patient presented to my office for a sleep and/or breathing disorder consultation on _____with chief complaints of:

☐excessive daytime sleepiness
☐chronic fatigue
☐history of snoring
☐nighttime bruxism
☐mouth breathing
☐headaches
☐observed to stop breathing during sleep
☐excess stress
☐trouble concentrating
☐Epworth Sleepiness Scale score _____
*(Please see enclosed Epworth Sleepiness Scale)

I am requesting your permission to prescribe OAT (Oral Appliance Therapy) to treat Obstructive Sleep Apnea.

Patient was administered a Home Sleep Apnea Test (HSAT) on _____ and **has been diagnosed with Obstructive Sleep Apnea** with an AHI of_____ ☐ mild ☐ moderate ☐ severe

*(Enclosed is a copy of the Sleep Study diagnosis)

☐ The patient is unable or unwilling to tolerate a CPAP.

My plan is to provide the patient with a Sleep Apnea Appliance to treat their OSA. Due to the diagnosis of **G47.33 Obstructive Sleep Apnea**, I have determined that it is medically necessary for this patient to be treated with oral appliance therapy.

☐ **Rx**: Sleep Apnea Appliance: **E0486** Oral device/appliance used to reduce upper airway collapsibility, adjustable or non-adjustable, custom fabricated, includes fitting and adjustment **OR K1027** Oral device/appliance used to reduce upper airway collapsibility, without fixed mechanical hinge, custom fabricated, includes fitting and adjustment

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OAT Prescription *(Ordering Doctor please check below)*

☒ **Rx**: I give permission to treat this patient with OAT (Oral Appliance Therapy)

Ordering Doctor/PCP Name (Please print): _____ NPI: _____

Ordering Doctor/PCP Signature: _____

Address_____

Phone: _____Fax: _____