

MD Prescription Referral for OAT (Oral Appliance Therapy)



SLEEP SOLUTION CENTERS

Dr. Tara Griffin - DMD, D. ABDSM, D. ASBA

Dr. Rupal Thakkar - DMD, Tufts Sleep Residency

Phone: 689-698-3389 GROUP NPI: 1982486510

Fax: 407-386-6920 or Email: Info@sscln.com

6424 Alexandra Louise Dr Ste 250 Orlando, FL 32827

Patient Name: _____ DOB: _____ Phone: _____ Date: _____

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

- | | |
|---|--|
| <input type="checkbox"/> excessive daytime sleepiness | <input type="checkbox"/> headaches |
| <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> observed to stop breathing during sleep |
| <input type="checkbox"/> history of snoring | <input type="checkbox"/> excess stress |
| <input type="checkbox"/> nighttime bruxism | <input type="checkbox"/> trouble concentrating |
| <input type="checkbox"/> mouth breathing | <input type="checkbox"/> 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

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:** _____