MD Prescription Referral for OAT (Oral Appliance Therapy)

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Patient Name: _____ DOB: _____Date_____

This patient presented to my office for a sleep and/or breathing disorder consultation on _____with 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)

Sleep Study date: _____ AHI: _____ RDI: _____ **Dx: G47.33 Obstructive Sleep Apnea**

After consulting with the patient, it has been determined the patient is unable or unwilling to tolerate a CPAP for the following reasons:

☐ Mask leaks / Inability to get mask to fit properly
☐ Discomfort caused by the straps and headgear
☐ Disturbed or interrupted sleep caused by the presence of device
☐ Restricts movements during sleep
☐ Does not seem to be effective
☐ Pressure on upper lip causes tooth-related problems
☐ Latex allergy
☐ Claustrophobic association
☐ Unconscious need to remove the CPAP apparatus at night
☐ Causes a dry nose or dry mouth
☐ An underlying medical condition that prevents them from wearing CPAP
☐ Other reason _____

Due to the history and 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 Treatment: E0486 or K1027

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

Ordering Doctor/PCP Signature: _____

Address_____

Phone: _____ Fax:_____