HEALTH & BEAUTY DENTISTRY

BY DR. SHAUNA PALMER

Referral Form for Oral Sleep Appliance

Patient's Information

First name:

Last name:

Birth date: (mm/dd/yyyy)

Gender: ◯ F ◯ M ◯ Other

Address:

Street:

City:

PC:

Province:

E-mail:

Phone:

Work phone:

Medical Necessity for Oral Appliance:

- CPAP intolerance ☐
- Primary snoring ☐
- Mild to moderate OSA ☐
- Rx consultation / Evaluation for oral appliance therapy ☐
- Adjunct to CPAP therapy ☐
- Inadequate surgical outcome ☐
- Other:

Patient is CPAP intolerant

Date PSG or HST performed:

Email or fax a copy to us: ◯ Yes ◯ No

Other services performed:

Diagnosis

Obstructive Sleep Apnea ☐ Primary snoring ☐ AHI ☐ RDI ☐

Other:

Referring Health Practitioner's Name:

First name:

Last name:

Office name:

Office Address:

Street:

City:

PC:

Province:

E-mail:

Phone:

Alt. phone:

Physician's Signature:

Date: (mm/dd/yyyy)

Fax Referral to: 778 - 754 - 8102 **Email to: reception@healthandbeauty.dentist**