CedarNorth SLEEP

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SLEEP REFERRAL

Name: Email:

Phone: Chief Complaint:

Please check off possible sleep related signs and symptoms

- ☐ Snoring
- ☐ Morning Headaches
- ☐ Sleep Apnea, diagnosed
- ☐ Daytime Sleepiness
- ☐ Intolerance to CPAP
- ☐ Sleep bruxism

Please check off possible sleep related signs and symptoms

- ☐ Headaches
- ☐ Neckaches
- ☐ Dizziness
- ☐ Ear Pain
- ☐ Fainting
- ☐ Sleep bruxism
- ☐ Limited jaw opening
- ☐ clenching
- ☐ Clicking or locking jaw
- ☐ Chronic Fatigue
- ☐ Tinnitus
- ☐ Shoulder or back pain

Message:

Please include a copy of the patient sleep study, an RX stating the patient is CPAP intolerant, and

the patients deographic sheet.

STATEMENT OF MEDICAL NECESSITY

This above patient has undergone a sleep study related breating disorder. this evaluation confirmed that an Oral Applicance is medically necessary, Oral Applicance Therapy (OAT) is used an alternative to surgery at this time and or CPAP, as this patient could not tolarate feel he/she will able to tolarate CPAP.

physician's Signature: _____ **Date:** _____