



CedarNorth SLEEP

Dr. Bettina Tong

7405 North Cedar Ave, Suite 102A
Fresno CA 93720

Phone: 559.432.4948

Fax: 559.432.4037

SLEEP REFERRAL

Name:

Email:

Phone:

Chief Complaint:

Please check off possible sleep related signs and symptoms

- | | |
|---|--|
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Daytime Sleepiness |
| <input type="checkbox"/> Morning Headaches | <input type="checkbox"/> Intolerance to CPAP |
| <input type="checkbox"/> Sleep Apnea, diagnosed | <input type="checkbox"/> Sleep bruxism |

Please check off possible sleep related signs and symptoms

- | | | |
|------------------------------------|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fainting | <input type="checkbox"/> Clicking or locking jaw |
| <input type="checkbox"/> Neckaches | <input type="checkbox"/> Sleep bruxism | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Limited jaw opening | <input type="checkbox"/> Tinnitus |
| <input type="checkbox"/> Ear Pain | <input type="checkbox"/> clenching | <input type="checkbox"/> 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 breathing disorder. this evaluation confirmed that an Oral Appliance is medically necessary, Oral Appliance 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: _____