SNORING & SLEEP APNEA
DENTAL TREATMENT CENTER

7225 Ohms Lane Suite 180 Edina, MN 55439
P 952.345.0290 F 952.920.0105
info@jparkerdds.com www.jparkerdds.com

Recommendation for Oral Appliance Therapy

To: Jonathan A. Parker, DDS
Jeffrey Forslund, DDS

Oral Appliance Order Form: **Fax: (952) 920-0105**

Patient: DOB:

Address: Ht: _____ Wt: _____

City,State,Zip: Sleep Study Date: _____

Telephone: H) AHI _____ RDI _____

Telephone: C) CPAP Pressure: _____

Diagnosis (please check)

__ Obstructive sleep apnea
__ Upper airway resistance syndrome
__ Narcolepsy
__ Periodic limb movement disorder
__ Restless leg syndrome
__ Primary Snoring

Treatment Orders (please check)

__ Mandibular Advancement Device for treatment of OSA
__ Mandibular Advancement Device to be used in combination with CPAP
__ Mandibular Advancement Device for treatment of primary snoring.
__ Positional Therapy (positional cushion to prevent supine sleep)
__ Other_____

Medical Justification (Patient has tried CPAP and has not tolerated and/or complied with treatment for the following reasons):

__ Unable to tolerate mask /straps
__ Unable to tolerate effective CPAP pressure
__ N/A
__ Skin sensitivity
__ Claustrophobia
__ Other_____

Due to the history and diagnosis noted above, I am recommending oral appliance therapy for the treatment of this patient. I, the undersigned, certify the procedure prescribed above is medically necessary for the treatment of this sleep disorder. I understand that the oral appliance will be needed for an indefinite period of time.

Referring Physician:_____(print) Phone:_____

Signature:_____ Date:_____