



**Snore No More Vegas**

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(702) 933-1300

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Phone: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Referring Dr's Phone: \_\_\_\_\_

Patient is being referred for an evaluation for Oral Appliance Therapy

HST / PSG Date: \_\_\_\_\_

Diagnosis:  OSA  Mild  Moderate  Severe

Patient currently uses a CPAP:  Yes  No

Patient declined CPAP or is CPAP intolerant:  Yes  No

Comments: