



## MD Prescription Referral for OAT (Oral Appliance Therapy)

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Date \_\_\_\_\_

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

This patient presented to my office for a sleep and/or breathing disorder consultation on \_\_\_\_\_ with chief complaints of:

- |                                                       |                                                                  |
|-------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Excessive daytime sleepiness | <input type="checkbox"/> Observed to stop breathing during sleep |
| <input type="checkbox"/> Chronic fatigue              | <input type="checkbox"/> Excess stress                           |
| <input type="checkbox"/> History of snoring           | <input type="checkbox"/> Trouble concentrating                   |
| <input type="checkbox"/> Nighttime bruxism            | <input type="checkbox"/> Epworth Sleepiness Scale score _____    |
| <input type="checkbox"/> Mouth breathing              |                                                                  |
| <input type="checkbox"/> Headaches                    |                                                                  |

\*(Please see enclosed Epworth Sleepiness Scale)

### Requesting Permission to Prescribe OAT for Obstructive Sleep Apnea

Patient was administered a Home Sleep Apnea Test (HSAT) on \_\_\_\_\_ and **has been diagnosed with OSA,**

☐ Mild ☐ Moderate ☐ Severe

Obstructive Sleep Apnea with an AHI of \_\_\_\_\_

\*(Enclosed is a copy of the Sleep Study diagnosis)

☐ **The patient is unable or unwilling to tolerate a CPAP.**

\*(Enclosed is a copy of the CPAP Intolerance Form)

My plan is to provide the patient with a Sleep Apnea Appliance to treat their OSA. Due to the diagnosis of **G47.33 Obstructive Sleep Apnea**, I have determined that it is medically necessary for this patient to be treated with oral appliance therapy.

☐ **Rx: Sleep Apnea Appliance: E0486**

### OAT Prescription (Ordering Doctor please check below)

☐ **Rx: I give permission to treat this patient with OAT (Oral Appliance Therapy)**

Ordering Doctor/PCP Name (Please print): \_\_\_\_\_ NPI: \_\_\_\_\_

Ordering Doctor/PCP Signature: \_\_\_\_\_

Address \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_