



Lane Sleep Solutions

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Email: drlane402@gmail.com

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: