



DEEP SLEEP REMEDIES

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Email: Info@BrettWarnDDS.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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_