SLEEP & AIRWAY CENTER

BETTER SLEEP. BETTER HEALTH. BETTER YOU.

Custom Sleep Apnea Mouth Appliance Treatment

Dr. Ashlee GOODMAN-TABARI

If you've received this card, it means your physician is recommending our services. **We look forward to helping** you reclaim restful nights.

Better Sleep. Better Life.

Your sleep schedule and health don't have to *suffer any longer.*

Patient Name: _____ Date of Birth: _____

Reason for Referral (Check all that Apply)

- ☐ Sleep Consult/Airway Evaluation
- ☐ Patient has been diagnosed with OSA
- ☐ Oral Appliance Therapy
- ☐ Mild ☐ Moderate ☐ Severe
- ☐ Patient is CPAP intolerant/noncompliant
- ☐ Not a canadidate and/or declines surgical procedures

Requested Information with this Form

- ☐ Copy of Medical Insurance or Medicare Card (Enlarged 150%)
- ☐ Copy of recent Sleep Study
- ☐ Signed Rx for Oral Appliance

Referring Physician: _____ Date: _____ NPI# _____

Printed Name: _____ Signature: _____

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