

Referral and Prescription for Oral Appliance Therapy



Thank you for the Referral to:

Cape Cod Sleep Solutions

William J. Scheier, DDS, D-ABDSM & Annisya Bagdonas, DDS, D-ABDSM

900 Route 134, Unit 3-24, South Dennis, MA 02660

Phone: (508) 240-2588 // Fax: (833) 229-8766

Patient name: _____ DOB: _____

Address: _____

Phone: _____

Date of referral: _____

FAX:

- Any Clinical notes prior to sleep study
- Sleep Study
- Signed Rx and Letter of Medical Necessity (this form)

Rx and Letter of Medical Necessity:

This patient has undergone a sleep study for a sleep related breathing disorder. A diagnosis has been made:

- Obstructive Sleep Apnea (G47.33)
- Snoring (R06.83)

I am prescribing an FDA approved Mandibular Advancement Device (E0486) for this patient as a medically necessary treatment.

Oral Appliance Therapy is used as an alternative to PAP and/or surgery.

Physician Name Print _____

Physician Signature _____

Please fax this form along with Sleep Study and Clinical Notes to **(833) 229-8766**