Prescription For OSA
Oral Appliance Therapy

THE SNORING & SLEEP APNEA CENTER

PRESCRIBING PROVIDER

Provider Name:_____ Provider NPI #: _____
Phone:_____ FAX:_____
Address: _____

PATIENT INFORMATION

Patient Name: _____ Patient DOB:_____
Phone:_____ Email:_____

TREATMENT RECOMMENDATION:

☐ The patient has MILD or MODERATE Obstructive Sleep Apnea and prefers Oral Appliance Therapy.

☐ The patient has Obstructive Sleep Apnea, has tried and failed CPAP therapy and would like to pursue Oral Appliance Therapy.

☐ The patient has SEVERE Obstructive Sleep Apnea but is unable or unwilling to try CPAP therapy and would like to pursue Oral Appliance Therapy.

The patient exhibits the following symptoms and co-morbidities associated with his/her diagnosis of Obstructive Sleep Apnea:

☐ Witnessed Apneas
☐ Gasping / Choking
☐ Mood Disorders
☐ Insomnia
☐ Ischemic Heart Disease
☐ History of Stroke
☐ Impaired Cognition
☐ Excessive Daytime Sleepiness / Fatigue
☐ Treatment Resistant Hypertension

PRESCRIPTION

☐ **Custom Oral Mandibular Advancement Device for the treatment of Obstructive Sleep Apnea (HCPC – E0486 or K)**

☐ Initial / New Order ☐ Replacement Order

DURATION: *Lifetime*

DIAGNOSIS CODE: G47.3

PROVIDER SIGNATURE: _____ DATE: _____

Please Fax this completed form to 206.770.0182