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PATIENT REFERRAL

DATE:_____

NAME:_____

ADDRESS:_____CITY:_____STATE:_____

DATE OF BIRTH:_____SSN_____

PHONE: (H)_____(W)_____(CELL)_____

PRIMARY INS:_____ID No:_____

SECONDARY INS:_____ID No:_____

REASON FOR REFERRAL-- Please include working diagnosis, pertinent physical and psychiatric findings:_____

HISTORY OF SLEEP STUDY
WHERE:_____DATE:_____
DIAGNOSIS:_____

Is patient currently on CPAP? YES____ NO____
Is patient currently on oxygen? YES____ NO____
Has patient had ENT evaluation? YES____ NO____

Current Medications:_____

Referring Physician:_____
Telephone:_____Fax:_____
Address:_____City:_____State:_____Zip:_____

****PLEASE INCLUDE SLEEP STUDY, LETTER OF MEDICAL NECESSITY AND A PRESCRIPTION FOR FABRICATION OF A MANDIBULAR REPOSITIONING ORTHOTIC.**