tmj-sleep colorado
therapies for facial pain and sleep disorders

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ORAL APPLIANCE REFERRAL AND FAX FORM

_____ _____ _____ _____
Patient Name DOB Prime Phone Secondary Phone

_____
Email Address

REFERRAL FOR:

□ Sleep Appliance (Newly or never been diagnosed □, or CPAP Intolerant □)
□ Snoring Appliance
□ Other: _____

DIAGNOSIS: (If known)

□ Obstructive Sleep Apnea – ICD 327.23
□ Hypersomnia due to Sleep Apnea – 780.53
□ Snoring 786.09
□ Other: _____

PLEASE ATTACH: (Please fax form and docs to our office, copy to patient)

□ Demographics
□ Insurance Cards (primary & secondary, front & back)
□ Polysomnography Report (If not attached where was it done:_____)
□ RX for oral appliance (MD only)

ADDITIONAL NOTES:

_____

_____

_____ _____ _____
Referring DDS or MD Signature Date

_____ _____
NPI # Office Ph# FAX #