REFERRAL FORM FROM CLINIC

REFERRAL DATE: ____________________________

FROM FACILITY: ____________________________ PHONE#: ________________________ FAX#: ________________

REFERRING PHYSICIAN: ______________________ SPECIALTY: ______________________ NPI#: ________________

PATIENT INFORMATION:

PATIENT NAME: ____

ADDRESS: ____

EMAIL: ___________________________________ EMPLOYER: ___________________________________

BEST DAYTIME #: ____ BEST EVENING #: ____

_____MALE _____FEMALE DOB: _________________________ MARITAL STATUS: _____S _____M _____D _____W

MEDICAL INSURANCE INFORMATION:

SUBSCRIBER INFORMATION: _________________________ DOB: _____________________ SS#: _____________________

INSURED COMPANY NAME: _________________________ INS CO PHONE#: ____

SUBSCRIBER ID: _________________________ GROUP #: ____

SYMPTOMS

_____FATIGUE/DAYTIME SLEEPINESS
_____WITNESSED APNEA
_____CHOKING/GASPING FOR AIR
_____OBESITY
_____SNORING
_____JAW PAIN
_____HEADACHES
_____NECKACHES
_____BRUXISM
_____DEPRESSION
_____RINGIN IN EARS/EAR PAIN
_____WEARS CPAP/INTOLERANT
_____LOSS OF ENERGY
_____ASTHMA
_____RESTRICTED AIRWAY
_____OTHER ____

ORDER/REQUEST:

_____EVALUATION FOR TMD/TMJ WITH CLINICAL EXAMINATION
_____PATIENT HAS BEEN DIAGNOSED WITH TMD/TMJ, BUT CURRENT APPLIANCE/THERAPY IS INEFFECTIVE
_____EVALUATION FOR POSSIBLE SLEEP BREATHING DISORDERS AND SLEEP STUDY REFERRAL
_____PATIENT HAS CPAP/BIPAP, BUT IS INTOLERANT**
_____PATIENT HAS BEEN DIAGNOSED WITH OBSTRUCTIVE SLEEP APNEA OR SIMPLE SNORING BUT NEVER TREATED**

****INCLUDE PATIENT MOST RECENT SLEEP STUDY & PRESCRIPTION FOR MANDIBULAR ADVANCEMENT DEVICE THERAPY**

PHYSICIAN SIGNATURE: ____