# TREATMENT REFERRAL

Please fax this form to our confidential fax line at 1-888-323-9589

Patient Name: _____ DOB: _____

Phone Number: _____

PHN: _____ Today's Date _____

THIS PATIENT HAS BEEN REFERRED TO DR. HALSTROM SLEEP APNEA AND SNORING CLINICS FOR TREATMENT OF OBSTRUCTIVE SLEEP APNEA WITH A MANDIBULAR REPOSITIONING APPLIANCE. USE OF THIS APPLIANCE IS REQUIRED INDEFINITELY. AS A PHYSICIAN, I DEEM THIS THERAPY TO BE MEDICALLY NECESSARY.

Please check if appropriate:

☐ Patient was unable to tolerate CPAP Therapy.

*Physicians Stamp*

Comments:

Referring Physician: _____

Signature: _____

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