TREATMENT REFERRAL

MANDIBULAR REPOSITIONING DEVICE *for* OBSTRUCTIVE SLEEP APNEA

Please Fax To 604-876-7121

Patient Name: ____________________________________ DOB DD/MM/YR): _____________

Phone Number: ____

PHN: __________________________ Today's Date ________________________

PATIENT HAS BEEN REFERRED FOR TREATMENT OF OBSTRUCTIVE SLEEP APNEA WITH A MANDIBULAR REPOSITIONING DEVICE. USE OF THIS DEVICE IS REQUIRED INDEFINITELY. AS A PHYSICIAN I DEEM THIS THERAPY TO MEDICALLY NECESSARY.

______ Patient was unable to tolerate CPAP.

Reason for intolerance: ____

_________________________________ _______________________________

REFERRING PHYSICIAN - DOCTORS STAMP **SIGNATURE**

Dr. Halstrom
Sleep Apnea & Snoring Clinics

Suite #101, 19329 Enterprise Way
Surrey, BC V3S 6J8

604-876-8993 Tel 604-876-7121 Fax
www.drhalstrom.com

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