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**

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