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.

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REFERRING PHYSICIAN - DOCTORS STAMP **SIGNATURE**

Dr. Halstrom™
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