Dr. Nipa Thakkar, DMD, MBS
Sleep Better Solutions at Thakkar Dental
"Dream Better, Sleep Better"

Rx for Oral Appliance Therapy for Medical Necessity for Diagnosed Obstructive Sleep Apnea

Patient Name: ____

Patient Phone: __________________________ **Referral Date**: _____________

Please provide treatment with oral appliance due to: (check all that apply)

- ☐ CPAP intolerant
- ☐ Mild/moderate obstructive sleep apnea
- ☐ Severe sleep apnea
- ☐ Primary snoring
- ☐ Insufficient surgical outcome

Any other comments:

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<u>Diagnosis:</u>

- ☐ Obstructive sleep apnea
- ☐ Insomnia due to sleep apnea
- ☐ Sleep apnea, other, unspecified
- ☐ Hypersomnia due to apnea
- ☐ Sleep apnea/sleep related breathing disorder
- ☐ Sleep related bruxism

Please fax to our office at 610-436-8553 and/or provide your patient with copy.

Physician name (print): ______________________________________

Physician Signature: ____

Phone: ________________________ Fax: ______________________________

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