Dr. Mohamad Shurbaji DMD

General and Cosmetic Dentistry

Dental Sleep Medicine

Member of the American Academy of Dental Sleep Medicine

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Oral Appliance Referral Form

Patient Information

Patient: ______________________________ DOB __________________Todays Date ____________

Phone: Home: _______________________Work: __________________Cell :_____________________

Email :____

Referring Provider's Information

Referring Physician's name ____

Phone: _____________________________________ Fax: _____________________________________

It may also be necessary to send an Out of Network referral to the patient's insurance company.

Diagnosis (please check)

___ Sleep apnea, obstructive (327.23)

___ Snoring (786.09)

___ other

Date of diagnostic sleep study_______________

____ polysomnogram

_____ Home Sleep test

* Please send a copy of the diagnostic Sleep Study

Treatment Orders (please check)

____ Custom fabricated Mandibular Advancement Appliance (E0486)

____Other ____

Medically Necessary:

Due to the history and diagnosis above, I am recommending oral appliance therapy for the treatment of this patient. I, undersign, certify the procedure prescribe above is medically necessary for the treatment of this sleep disorder.

Referring Physician: (print) ____

Signature: ____Date :___________________

Please fax or mail this completed form to our office.