** Dr. Cecilia Ng, DMD**

**#603 – 1788 West Broadway**

**Vancouver, BC V6J 1Y1**

**604-318-8633**

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| **Referral For Oral Appliance Therapy** |

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB (dd/mm/yy): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pt Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pt Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_**

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| **DIAGNOSIS: (Please Check)** |

**Obstructive Sleep Apnea Insomnia du to Sleep Apnea**

**UARS Hypersomnia due to Sleep Apnea**

**Primary Snoring  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **MEDICAL JUSTIFICATION:** |

**Unable to tolerant mask/strap/pressure**

**Reasons the patient cannot tolerate CPAP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Statement of Medical Necessity**

**This above patient has undergone a sleep study and was diagnosed with obstructive sleep apnea. Obstructive sleep apnea is a medical condition which requires treatment. CPAP is a treatment option but this patient is cannot tolerate CPAP. Therefore, it is a medical necessity to treat this patient for this medical condition using an Oral Appliance as an alternative to CPAP.**

**Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Office Stamp**

**Please fax this form to 604-608-9331**

**or email to** [**info@osasolutions.ca**](mailto:info@osasolutions.ca)