Dr. Roger Roubal

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ADVANCED DENTAL SLEEP TREATMENT CENTER

Referral Form For Oral Appliance Evaluation

PATIENT INFORMATION

Full Name: _____
Last *First* *M.I.*

Home Phone: ( ) _____ Cell Phone: ( ) _____ Work Phone: ( ) _____

Insurance Provider: _____

Sleep Study Available: YES ☐ NO ☐ DON'T KNOW ☐

REASON FOR REFERRAL (MARK ALL THAT APPLY)

Diagnosed: ☐ Obstructive Sleep Apnea (ICD 327.23)

☐ Other _____

Therapies Attempted: CPAP ☐ NONE ☐

Surgery ☐

Non-Diagnosed: ☐

Comments/Special Concerns: _____

_____

Requesting Provider's Name: _____ Date: _____
(Please Print)

Office Phone : ( ) _____ Office Fax: ( ) _____