



Salem Akkad DDS, MS

17721 Dallas Pkwy #116, Dallas, TX 75287

Phone: 469-685-1700 Fax: 888-491-6582

www.simplesleepservices.com

## Referral For Oral Sleep Appliance Therapy

### Patient Information

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City & Zip: \_\_\_\_\_ State \_\_\_\_\_

Cell #: \_\_\_\_\_

Home #: \_\_\_\_\_

Work #: \_\_\_\_\_

SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

### Patient's Insurance Information

Carrier: \_\_\_\_\_

Phone: \_\_\_\_\_

Group No: \_\_\_\_\_

ID No: \_\_\_\_\_

Person Insured: \_\_\_\_\_

Insured SSN: \_\_\_\_\_

Insured DOB: \_\_\_\_\_

Clinical Observations					
<input type="checkbox"/>	Loud Snoring	<input type="checkbox"/>	Restless Sleep	<input type="checkbox"/>	Obese/Large neck
<input type="checkbox"/>	Witness Apneas	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Dry Mouth
<input type="checkbox"/>	Daytime Drowsiness	<input type="checkbox"/>	GERD	<input type="checkbox"/>	Regtrognathia
<input type="checkbox"/>	Loss of Energy/Fatigue	<input type="checkbox"/>	Morning Headaches	<input type="checkbox"/>	Enlarged Tongue

### **Patient referred to Simple Sleep Services be evaluated for oral appliance therapy (OAT) due to:**

- The patient has been diagnosed with obstructive sleep apnea: *mild mod severe AHI*: \_\_\_\_\_
- CPAP Intolerance
- Primary Snoring
- Surgical Result Inadequate
- Adjunctive therapy to CPAP or Surgery
- Additional comments regarding patient's history of OSA therapy:

### • A copy of the following -if available- should be faxed to office prior to consult appointment:

- The most recent **complete** diagnostic PSG (i.e., long report)
- The summary CPAP trial PSG (if patient had one)

Referring Physician: \_\_\_\_\_

Office Address: \_\_\_\_\_

City & Zip: \_\_\_\_\_ State \_\_\_\_\_

Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_