THE SLEEP TEAM
ALTERNATIVES FOR CPAP & SNORING
Olga Rodriguez-Valle, DMD
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P: 702-518-5151 F: 702-799-9831

Patient Name: _____ DOB: _____
Address: _____
Phone: _____ Email: _____
Insurance: _____
ID#: _____ Group #: _____

Prescription for Mandibular Advancement Device (Oral ApplianceTherapy)

The patient referred with this form has been evaluated by the physician and has been diagnosed with:

[ ] Mild to Moderate OSA (G47.33)
[ ] CPAP Intolerance
[ ] Inadequate Surgical Results
[ ] Daytime Sleepiness (G47.10)
[ ] Adjunct to CPAP Therapy
[ ] Primary Snoring R06.83
[ ] Hypertension (I10)
[ ] Patient Preference

The patient has a sleep test: [ ] Yes [ ] No [ ] PSG [ ] HST * Please fax if available*

I am prescribing treatment utilizing an FDA approved, custom-made, titratable Mandibular Advancement Device (E0486) for the above named patient who has been diagnosed with Obstructive Sleep Apnea (G47.33). *As the referring provider, I deem this therapy to be medically necessary. Length of need is lifetime.*

Prescription to be filled by: Olga Rodriguez-Valle, DMD.
Special Instructions: _____
_____

Provider Name: _____
Address: _____
Phone: _____ Fax: _____

Provider Signature: _____ Date: _____

*Obstructive Sleep Apnea Is a medical condition that tends to become more severe with time and requires periodic re-evaluation by a qualified physician.

Please include patient demographics, insurance, appointment notes, and sleep study (if available).

FAX ALL REFERRALS TO: 702-799-9831
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