

Rx For Oral Appliance Therapy for Obstructive Sleep Apnea*

Physician: _____ Telephone: _____
Office Address: _____
Patient Name: _____
Patient Address: _____
Patient Telephone: _____

Prescription to be filled by:
B. Gail Demko, DMD, D.ABDSM Francis A. Harrington, DMD
www.SleepApneaDentist.com

140 Merriam St., Weston , MA 02493
Mailing address: P.O. Box 606, Weston, MA 02493
Appointment Line: 617-964-4028 FAX: 617-467-4751
FAX: 617-595-4591

The patient referred with this form has been evaluated by the above physician and has been diagnosed , using acceptable medical criteria, to have:

- Obstructive sleep apnea or Severity _____
- Simple Snoring: _____

This patient is :
 Intolerant of CPAP therapy
 Is not a candidate for CPAP therapy
Explanation (if necessary): _____

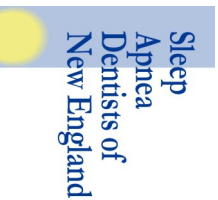
The patient is being sent for OA therapy with:
 The appliance chosen by the dentist and the patient as most suitable
 A _____ appliance (specific name)
Signature of Referring Physician: _____

***As a physician, I deem this therapy to be medically necessary.**

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.
Oral Appliance Therapy is less effective in controlling this disease than CPAP , and patients referred for this therapy may need to explore additional options of treatment if the appliance alone is deemed to provide suboptimal management of the sleep apnea.
Copies of diagnostic and PAP titration PSG with full report are required for appropriate care and to obtain medical insurance coverage.

Original Prescription should be mailed or delivered to SADoNE@gmail.com



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