

Prescription 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, D.M.D.

www.SleepApneaDentist.com

Credentialed by the Academy of Dental Sleep Medicine

Expert Advisor to the FDA Dental Products Panel

271 Auburn St., Auburndale, MA 02466

Appointment Line: 617-964-4028 cell: 617-921-7666 FAX: 508-875-0712

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 Dr. Demko 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 Sleep Studies with full report are required by Dr. Demko for appropriate care and to obtain medical insurance coverage.

Original Prescription MUST be mailed or delivered to Dr. Demko