

LOUISVILLE DENTAL SLEEP MEDICINE
JOHN M MCCRILLIS DMD
Diplomate, American Board of Dental Sleep Medicine
2902 Taylorsville Road, Louisville KY 40205
502-458-7476

ORAL APPLIANCE ORDER FORM

FAX TO: (502) 451-5857

Patient:

DOB:

Address:

Height:

Weight:

Telephone: H

Sleep Study Date:

W/Cell

CPAP Pressure:

Diagnosis: (please check)

Obstructive Sleep Apnea

Periodic Limb Movement

Restless Leg Syndrome

Reactive Airway Disease

Other:

ORDERS:

Mandibular Advancing Device (Oral Appliance for treatment of OSA)

Other:

MEDICAL JUSTIFICATION: Patient has attempted CPAP and has not complied for the following reason(s):

Unable to tolerate Mask/Straps

High CPAP pressure. Patient may benefit from appliance or combination appliance/CPAP therapy

Other

Due to the above noted history and physical information I am recommending an Oral Appliance for treatment of this patient. I, the undersigned, certify the above prescribed procedure is medically necessary in the treatment of this diagnosis.

Referring Physician:

Phone:

Fax:

Signature:

Date:

CALL OUR OFFICE TO SCHEDULE AN APPOINTMENT: (502) 458-7476

APPOINTMENT Date _____ Time _____

OFFICE LOCATION: 2902 Taylorsville Road Exit 17 from I-264, across from Bowman Field, next to Bearno's Pizza.