OFP, TMJ & DSM Specialists

Amit Wadke BDS, MS, MHA

Please submit your referral to:
Ph: (425) 322-1TMJ
Fax: (425) 297-4652
Email: info@ofp-specialists.com

Rx for Oral Appliance Therapy for Obstructive Sleep Apnea

Referring Clinician Information **Date:** _____
Practice: _____
Phone: _____ Fax: _____
Clinician Name: _____
Signature: _____

Patient Information
Name: _____ DOB: _____
Phone: _____ Email: _____
Comments:

- ☐ Please call patient to schedule appointment
- ☐ Patient will call to schedule appointment
- ☐ Patient is ambulatory. Please call: ☐ Patient ☐ POA

Please provide Rx with oral appliance due to the following (check all that apply):

- ☐ CPAP Intolerant
- ☐ Snoring
- ☐ Mild/Moderate/Severe OSA
- ☐ Adjunct to CPAP Therapy
- ☐ Insufficient Surgical Outcome
- ☐ Other: _____

Diagnosis

- ☐ Obstructive Sleep Apnea – G47.33
- ☐ Sleep Apnea Unspecified – G47.30
- ☐ Other: _____
- ☐ Snoring – R06.83
- ☐ Sleep Related Bruxism – G47.63

Patient has a diagnostic polysomnogram report ☐ Yes ☐ No

Relevant History/Notes:

_____
_____
_____
_____