SleepAlliance

**TOLL FREE** 800-619-4672

**PHONE** 619-299-6299

**FAX** 619-299-6222

**San Diego Location**
5471 Kearny Villa Rd, Ste 200
San Diego, CA 92123

# Dental Sleep Medicine Referral Form

Please include as much information as possible regarding the patient and attach any patient's clinical history, insurance info, and demographics.

## Section 1: Patient Information (required)

PATIENT NAME:

ADDRESS, CITY, STATE, ZIP:

DOB:

HOME PHONE:

CELL PHONE:

WORK PHONE:

REFERRING PHYSICIAN:

ADDRESS, CITY, STATE, ZIP:

PHONE:

FAX:

EMAIL:

CA LICENSE:

NPI:

## Section 2: Medical History & Reason For Referral (required)

- ☐ **COPD**
- ☐ **Mood Disorder**
- ☐ **Excessive Daytime Sleepiness**
- ☐ **Diabetes**
- ☐ **Hypertension**
- ☐ **History of OSA (G47.33)**
- ☐ **Cardiac Disease**
- ☐ **Obesity**
- ☐ **Snoring**
- ☐ **Stroke**
- ☐ **CPAP Intolerant**

## Section 3: Sleep Disorders/Diagnostic Services (required)

- ☐ **Please initiate oral appliance therapy for OSA. (E0485, E0486, 99203, 99213, 70486)**
- ☐ **Please evaluate current oral appliance for adjustments or repairs. (L4204, L4210)**
- ☐ **Oral appliance replacement (E0486)**

PRACTITIONER SIGNATURE

SPECIAL REQUESTS

DATE

PATIENT INSURER NAME AND INSURANCE ID#