ANGELLIFT
DENTAL SLEEP CENTER

Jim Hales DDS

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Phone: 541-474-1100

PATIENT INFORMATION

Full Name: _____
Last First M.I.

Address: _____
Street Address Apartment/Unit #

_____
City State Zip Code

Home Phone: ( ) _____ DOB: _____ Email: _____

Requesting Physician's Name: _____ Email: _____

Insurance Provider: _____

Policy Number: _____ Group Number: _____ Employer: _____

Insured: Self ◯ Child ◯ Other ◯ Medicare: YES ◯ NO ◯

Sleep Study Available: YES ◯ NO ◯

REASON FOR REFERRAL (MARK ALL THAT APPLY)

Diagnosis:

☐ **Obstructive Sleep Apnea (ICD G47.33)**

☐ Sleep Apnea/Sleep Related Breathing Disorder, Unspecified (ICD G47.30)

☐ Insomnia due to Sleep Apnea (ICD G47.30)

☐ Hypersomnia due to Sleep Apnea (ICD G47.30)

☐ Headaches (ICD G44.1)

☐ TMJ Disorders (ICD M26.60)

Rx:

☐ **Fabricate Custom Oral Appliance**

Therapies Attempted:

CPAP: Intolerant ☐ Not a good candidate ☐ Surgery: YES ☐ NO ☐

Comments/ Special Concerns: _____

Please include a copy of the patients sleep study, an RX stating the patient is CPAP intolerant, and the patients demographic sheet.

STATEMENT OF MEDICAL NECESSITY

This above patient has undergone a sleep study for a sleep related breathing disorder. This evaluation confirmed that an Oral Appliance is medically necessary. Oral Appliance Therapy (OAT) is used as an alternative to surgery at this time and or CPAP, as this patient could not tolerate CPAP or does not feel he/she will be able to tolerate CPAP.

Physician's Signature: _____ Date: _____