(704) 266-0808
10230 Berkeley Pl Dr # 200,
Charlotte, NC 28262

Monday-Friday 9:00am-5:00pm

Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea (OSA)*

Referring Physician: _____ Tel: _____
Patient Name: _____
Patient Address: _____
Patient Telephone: _____
Please fax copy of patient's medical insurance card with this prescription.

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-
☐ Simple Snoring

Severity: _____

This patient is:

☐ Intolerant of CPAP therapy
Explanation (if necessary):

☐ Is not a candidate for CPAP therapy

_____
_____

Notes:

_____
_____
_____

Signature of Referring Physician: _____
Date: _____ *As a physician, I deem this therapy to be medically necessary.*

Please fill out this prescription in its entirety.
**Obstructive Sleep Apnea is a medical condition that tends to become more severe with time and requires periodic re-evaluation by a qualified physician.*

Submit