DATE:

Please include copies of any recent sleep studies.

EMAIL BACK TO:

Referring Provider: Dr. Erin Priemer

Phone: 416-439-6776

Email: sleep@scarboroughdental.ca

Clinic Name: Scarborough Dental Sleep & Snoring Therapy

Address: 300-2100 Ellesmere Road, Scarborough, ON M1H 3B7

LETTER OF MEDICAL NECESSITY / REFERRAL FORM FOR ORAL APPLIANCE THERAPY

Patient Name:	**DOB: _____/_____/_____ Age: _____**
Patient Phone #:	**Patient Address:**
Insurance Company: **Policy No:** **Member ID No:**	**Health Card (OHIP):**

Prescribing Physician:

Primary Diagnosis: ◯ Obstructive Sleep Apnea ◯ Snoring

Secondary Diagnosis (Comorbidities):

Is this patient intolerant of PAP or not a candidate for PAP therapy?

❑ Intolerant of PAP ❑ Not a candidate for PAP ❑ Prefers not to use PAP

Duration of PAP Treatment:

Start Date _____ End Date _____ Still Currently Using _____ Yes _____ No

Description of Oral Appliance: *ORAL APPLIANCE USED TO REDUCE UPPER AIRWAY COLLAPSIBILITY, ADJUSTABLE OR NON-ADJUSTABLE, CUSTOM FABRICATION and INCLUDES FITTING AND ADJUSTMENTS*

I have attached the following documents needed to proceed with oral appliance treatment:

❑ Medical History and Medications

❑ Current Progress Notes

❑ Diagnostic Sleep Study

❑ PAP Trial Study

Physician Signature: _____ **Date:** _____

Statement of medical necessity: The above patient had a sleep-disordered breathing evaluation. This evaluation confirmed the diagnosis of obstructive sleep apnea. This evaluation confirmed that an ORAL APPLIANCE is medically necessary.

If you should have any questions, please contact the prescribing physician.