INNOVATIVE
DENTAL SLEEP
& TMJ SOLUTIONS
OF RENO

REFERRAL FORM

Patient Name: ______________________________ Date of Birth: __________

Referral for:

- ☐ Sleep Consult/ Airway Evaluation
- ☐ OAT (Oral Appliance Therapy)
- ☐ Patient has been diagnosed with OSA — Mild ☐ Moderate ☐ Severe ☐
- ☐ Patient is CPAP intolerant/noncompliant
- ☐ **TMJ** (Temporomandibular Joint Dysfunction)

Requested information with this form *(Please fax to: 775-358-3817)*

- ☐ Copy of Medical Insurance or Medicare Card (Enlarged 150%)
- ☐ Copy of recent (long form) Sleep Study
- ☐ Signed RX for Oral Appliance

Referring Physician

Date: ______________

____
Printed Name

____
Signature

____
NPI#

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