bettersleepdental.ca

Referral form for Assessment for Oral Appliance Therapy
For Snoring/Obstructive Sleep Apnea
Fax: (705) 526-0233

- ☐ Assess patient for treatment of primary snoring
- ☐ Assess patient for treatment of Obstructive Sleep Apnea
- ☐ Patient has not been able to tolerate CPAP
- ☐ Patient prefers to use oral appliance therapy
- ☐ Patient requests oral appliance for occasional wear in addition to CPAP
- ☐ Patient needs CPAP and oral appliance
- ☐ Other_______________________________________

Note: If available, please send PSG report including data pages with referral. Fax number: (705) 526-0233

Dentists can play an important role in your chain of care. We will perform a thorough evaluation and consultation with the patient on the benefits and limitations of oral appliance therapy. The patient will be referred back to you for follow-up evaluation if they elect oral appliance therapy, or you will be contacted if they decline.

Patient Information:

Name:____

Address:____

Preferred daytime phone number:____

Email:____

Referred by:

Your name:____

Signature:____

Phone:_________________________________Fax:____________________________

Additional referral forms can be downloaded from bettersleepdental.ca

Dr. Donald Farquhar DDS, Diplomate ABDSM, Practice limited to treatment of snoring and obstructive sleep apnea
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