CHATTANOOGA SLEEP ASSOCIATES
AT LUNN DENTISTRY
THE CARE YOU DESERVE, THE EXPERIENCE YOU TRUST

Dentist: Oral Appliance Referral Form For Treatment of Obstructive Sleep Apnea

Patient's Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ DOB: _____ E-mail: _____

Requesting Dentist: _____
Dentist's Name *Dentist's E-mail*

Medical Insurance Information:
Insurance Provider:
☐ HMO ☐ PPO ☐ POS ☐ EPO ☐ Indem ☐ MCR ☐ MCD

_____
Policy Number *Group Number* *Employer*

Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Sleep Study Available: ☐ Yes ☐ No Medicare: ☐ Yes ☐ No

Reason For Referral (Mark All That Apply)

Diagnosis, if any:

☐ Obstructive Sleep Apnea (ICD 327.23)
☐ Hypersomnia due to Sleep Apnea (ICD 780.53)
☐ Insomnia due to Sleep Apnea (ICD 780.51)
☐ Other, Unspecified (ICD 780.57)
☐ Sleep Apnea / Sleep Related Breathing Disorder, Unspecified (ICD 327.20)

Baseline Sleep Study Data (PSG) Without Appliance (PAP Or Oral Appliance) if available:

Respiratory Disturbance Index (RDI) _____ Lowest Desaturation (SpO2) _____

Apnea Hypopnea Index (AHI) _____ Percentage or Amount of Time Below 90% _____

Therapies Attempted:

PAP: ☐ Intolerant ☐ Not a good candidate Surgery: ☐ Yes ☐ No

Other: _____ Successful PAP Pressure: _____

Comments / Special Concerns: _____

Statement Of Medical Necessity

I am requesting that Dr. Lunn evaluate my patient and treat, if medically necessary.

Dentist's Signature: _____ Date: _____

Thank you for your referral. If you have any questions please contact us at:

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