LOVE SLEEP

Patient Referral

Oral appliance therapy for sleep apnea and snoring

FAX 316-440-4426 · PHONE 316-440-9700

PATIENT

Patient name

Date of birth

Phone

Address

Email

Medical insurance (optional)

Member ID (optional)

REFERRING PROVIDER

Provider name and credentials

Practice

NPI

Phone

Fax

Email

REASON FOR REFERRAL

- ☐ OSA, intolerant of CPAP
- ☐ OSA, prefers an alternative to CPAP
- ☐ OSA, combination therapy with CPAP
- ☐ Primary snoring (OSA ruled out)
- ☐ Not yet diagnosed: please coordinate a home sleep test
- ☐ TMJ / TMD evaluation

Other

Relevant history, CPAP experience or notes

PLEASE ATTACH

Sleep study report · Recent office notes · CPAP download or compliance report (if applicable) · Prescription for oral appliance therapy

No prescription yet? Use the Love Sleep Oral Appliance Therapy Prescription form, available on the For Physicians page.

☐ Send me the consultation summary

Referring provider signature

Date

Contains protected health information. Send by fax or secure channel only.