

Prescription For Oral Appliance Therapy for Obstructive Sleep Apnea*

Referring Physician: _____ NPI: _____

Office Address: _____

Office Telephone: _____ Fax: _____

Patient Name: _____ DOB: ____/____/____

Patient Address: _____

Patient Telephone: _____

Prescription to be filled by: Dr. Mitch Conditt
451 University Dr, Ste 102 | Fort Worth, TX 76107
P: 817-527-8500 | F: 817-527-8512

The patient referred with this form has been evaluated by the above physician and has been diagnosed, using acceptable medical criteria, to have:

- Obstructive Sleep Apnea Mild Moderate Severe
 Simple snoring

- The patient is: Intolerant of CPAP therapy
 Is not a candidate for CPAP therapy

Explanation (if necessary): _____

The patient is being sent for Oral Appliance (OA) therapy with:

- The appliance chosen by Dr. Conditt and the patient as most suitable
 A _____ appliance (*specific name*)

Signature of referring physician:

_____ Date: _____

*As a physician, I deem this therapy to be medically necessary.