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, DDS
5722 Locke Avenue | 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.