Worcester Sleep Dentistry

DATE:

REFERRAL FORM FOR SLEEP

Referring Provider:

Clinic Name:

Phone:

Fax:

Patient Name:	**DOB: _____/_____/_____ Age: _____** **Gender Assignment at Birth:○ Male○ Female**
Patient Phone #: **Cell:** **Home:** **Work:**	**Patient Address:**
Insurance Company (Attach copy of card): **Name:** **Group No:** **Account/ID No:**	

Pertinent screening information is below:

Reason for Referral: Evaluate for oral appliance therapy

◯ Obstructive sleep apnea diagnosis: _____mild _____moderate _____severe

STOP-Bang Score: _____ Epworth Sleepiness Scale Score: _____ Berlin Score: _____

Neck circumference: _____ BMI: _____

Patient-reported conditions:

- Witnessed apneas
- Snoring

Patient-reported co-morbidities:

- Atrial fibrillation
- Chronic heart failure
- COPD
- Heart attack
- Hypertension
- Restless legs syndrome
- Stroke
- Type 2 diabetes

◯ I want to be notified of appointment date/time.