DENTAL SLEEP SOLUTIONS of Greenville

SLEEP APNEA & SNORING TREATMENT

DR. KYLE M. SMITH

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Prescription for Oral Sleep Appliance

Patient Name: _____
Patient Date of Birth: _____
Address: _____
Phone: _____
City, State, Zip: _____

Clinical Observations (circle)

Loud Snoring	Restless Sleep	Obese/Large neck
Witness Apneas	High Blood Pressure	Dry Mouth
Daytime Drowsiness	GERD	Regtrognathia
Loss of Energy	Morning Headaches	Enlarged Tongue

Patient referred to Dr. Kyle Smith to be evaluated for **oral appliance therapy (OAT)** due to:

___The patient has been diagnosed with obstructive sleep apnea: mild, mod, severe, AHI: _____
___CPAP Intolerance
___Primary Snoring
___Surgical Result Inadequate
___Adjunctive therapy to CPAP or Surgery
___Additional comments regarding patient's history of OSA therapy:

_____

Please send to office prior to consult appointment:

1- The most recent complete diagnostic PSG or homes sleep study.
2- The summary CPAP trial PSG (if patient had one)

Referring Physician: _____
City & Zip: _____State _____
Office Phone: _____

Physician Signature: _____Date: _____

We also request that you please order a sleep study (PSG or HST) for this patient, if needed.