PATIENT REFERRAL

NJ DENTAL SLEEP MEDICINE CENTER
DR. SUNITA MERRIMAN

Patient Name:_____ Phone:_____

Appointment Date & Time:_____

Please call 908-389-0222 to schedule your patient's appointment.

PLEASE BRING THIS FORM TO YOUR APPOINTMENT.

Date of Sleep Study:_____ Sleep Laboratory:_____

Diagnosis:

- ☐ Obstructive Sleep Apnea
  - ☐ Mild ☐ Moderate ☐ Severe
- ☐ Insomnia due to Sleep Apnea
- ☐ Hypersomnia due to Sleep Apnea
- ☐ Sleep Apnea (other/unspecified)
- ☐ Primary Snoring
- ☐ Other:_____

Sleep Study Results without Appliance:

Respiratory Disturbance Index (RDI) _____
Apnea Hypopnea Index (AHI) _____
Lowest desaturation (SpO2) _____
Percentage of time below 90% _____

Sleep Study Results with Appliance:

Respiratory Disturbance Index (RDI) _____
Apnea Hypopnea Index (AHI) _____
Lowest desaturation (SpO2) _____
Percentage of time below 90% _____

Treatment Orders:

- ☐ Mandibular Advancement Device for treatment of OSA
- ☐ Mandibular Advancement Device to be used in combination with CPAP
- ☐ Mandibular Advancement Device for treatment of Primary Snoring
- ☐ Matrix Titration Study

Medical Justification for the Recommendation of a Mandibular Advancement Device:

- ☐ Mild sleep apnea
- ☐ Moderate sleep apnea
- ☐ Unable to tolerate mask/strap
- ☐ Unable to tolerate effective CPAP pressure
- ☐ Skin sensitivity
- ☐ Claustrophobia
- ☐ Insufficient surgical outcome
- ☐ Other:_____

Rx:

Statement of medical necessity: This patient has undergone a sleep study for a sleep related breathing disorder. This evaluation confirmed the diagnosis, and a Mandibular Advancement Device is medically necessary due to the justification(s) identified above.

Physician Name:_____ Phone:_____ Signature:_____

Medical License #:_____ NPI #:_____

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