eugene
dental sleep
center

provider referral for oral appliance therapy

introducing my patient		referral date	
patient's name			
patient's phone		dob	
patient's email		sleep study	◯ Y * ◯ N

* please fax sleep study to 541-844-1370

reason for referral

◯ primary snoring ◯ mild/moderate sleep apnea ◯ CPAP intolerant

◯ adjunct to CPAP ◯ other:

comments	

referring provider		name	
phone		fax	
email			
signature			

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