INNOVATIVE
DENTAL SLEEP
& TMJ SOLUTIONS
OF RENO

REFERRAL FORM

Patient Name: _____ Date of Birth: _____

Referral for:

- ☐ Sleep Consult/ Airway Evaluation
- ☐ OAT (Oral Appliance Therapy)
- ☐ Patient has been diagnosed with OSA — Mild ☐ Moderate ☐ Severe ☐
- ☐ Patient is CPAP intolerant/noncompliant
- ☐ **TMJ** (Temporomandibular Joint Dysfunction)

Requested information with this form *(Please fax to: 775-360-4131)*

- ☐ Copy of Medical Insurance or Medicare Card (Enlarged 150%)
- ☐ Copy of recent (long form) Sleep Study
- ☐ Signed RX for Oral Appliance

Referring Physician

Date: _____

_____ _____

Printed Name Signature

_____

NPI#

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Jason R. Doucette, *DMD, DABDSM, DASBA*

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