Practice Information:

Address:

Phone:

Fax:

Homepage:

Email:

Clinical Notes: Oral Appliance Therapy for OSA

Date (M/D/Y): ______ / ______ / ______

Patient Name: ______________________

Age: ________ Gender: Male / Female

CLINICAL INFORMATION

Sleep physician:
Current medication:
Meds to sleep:
Chief complaint:
Symptoms:
Has patient tried CPAP?: Yes / No
Other therapies tried:
Height: ' "
Weight: lbs
BMI: $/m^2$
Neck size: inches
EPWORTH score:
DX:
AHI:
RDI:
Lowest O2 desat (NADIR): %
Resting pulse O2:
Resting heart rate:
Pretreatment photos taken: Yes / No
Panorex taken: Yes / No
Last dental exam:

DENTAL/ORAL EXAM

Oral habits (Grinding/Clenching):	
Soft/Hard tissue evaluation:	
Mobility:	
Contacts/Missing teeth: (Charted)	
Dental treatment advised:	
Maxilla shape, Abnormalities:	
Mandibular arch shape/Jaw size:	
Periodontal evaluation:	
Plaque/Calculus:	
Tongue size:	Scalloped tongue?: Yes / No
Palate: Valuted / Domed	Uvula size:
Mallampati score:	Tonsillar grading:
Occulusion class:	Midline:
Overbite:	Overjet:
Max vertical opening:	
Retrusive/Protrusive (Max horizontal range of motion):	
TMJ (signs or symptoms of dysfunction): None If any:	
Muscle of mastication palpation:	
Cottle maneuver: Positive / Negative	

IMPRESSIONS / BITE REGISTRATION

Impressions of maxilla/mandible taken
: ______________________

George gauge bite registration
: ________ mm / ________ fork

TREATMENT

Oral appliance Recommended: ______________________

Reason(s) for choosing OA type: ______________________

Ball clasps (Yes/No) and why? ______________________

Soft lining (Yes/No) and why? ______________________

Anterior window (Yes/No) and why? ______________________

Oral appliance delivered/inserted with follow up instructions
: ______________________

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