

Dental Office:

Office Address: _____

Phone: _____

Fax: _____

Homepage: _____

Email: _____

Physician Name: _____

Physician Address: _____

Patient Information

Name: _____

Date of birth: _____

Date of consultation: _____

Prescribed Oral Appliance: _____

Dear _____

You patient seen in our office for a consultation regarding construction of an oral appliance to treat sleep apnea.

As a result of our clinical examination and evaluation of the patient's sleep study, based on your prescription, it was determined that he/she is a good candidate for the oral appliance.

Our program consists of a comprehensive examination, thorough records and impressions of the upper and lower arches to construct an oral appliance with close observation and frequent maintenance appointments. A follow-up sleep study will be recommended upon significant relief of symptoms. The patient will be referred back to your office for continued care.

Clinical examination reveals the following:

- Patient's Chief Complaint: _____
- AHI: _____
- BMI: _____
- NADIR %: _____ %
- Malampatti Score: _____
- Scalloped Tongue: _____

We will inform you when the oral appliance is inserted. Thank you for your continued collaboration and patient referrals. If you have any questions or comments, please feel free to contact me at a mutual convenient date and time.

Sincerely,

Dental Office: XXXXXXXXXXXXXXXXXX

Office Address: XXXXXXXXXXXXXXXXXX
XXXXXXXXXX NY XXXXX

Phone: (XXX) XXX-XXXX

Fax: (XXX) XXX-XXXX

Homepage: https://XXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXX

Email: XXXXXXXXXXXX@XXXX

Physician Name: Dr. XXX

Physician Address: XXXXXXXXXXXXXXXXXX

XXXXXXXXXX NY XXXXX

Patient Information

Name: XXXXXX, XXXXX

Date of birth: DD/MM/YY

Date of consultation: DD/MM/YY

Prescribed Oral Appliance: XXXXXXXXXXXXXXXXXX

Dear Dr. XXX

You patient seen in our office for a consultation regarding construction of an oral appliance to treat sleep apnea.

As a result of our clinical examination and evaluation of the patient's sleep study, based on your prescription, it was determined that he/she is a good candidate for the oral appliance.

Our program consists of a comprehensive examination, thorough records and impressions of the upper and lower arches to construct an oral appliance with close observation and frequent maintenance appointments. A follow-up sleep study will be recommended upon significant relief of symptoms. The patient will be referred back to your office for continued care.

Clinical examination reveals the following:

- Patient's Chief Complaint: XXXX
- AHI: XXXX
- BMI: XXXX
- NADIR %: XXXX%
- Malampatti Score: XX
- Scalloped Tongue: Yes/No

We will inform you when the oral appliance is inserted. Thank you for your continued collaboration and patient referrals. If you have any questions or comments, please feel free to contact me at a mutual convenient date and time.

Sincerely,

XXXX XXXXX, DDS

XXXXXXXXXXXXXXXXXXXXXX

XXXXXXXXXXXXXXXXXXXXXX