Letter of Case Report

Dental Office:

Office Address: _____ Phone: _____

_____ Fax: _____

Homepage: _____ Email: _____

Physician Name: _____

Physician Address: _____

_____

Patient Information
Name:
Date of birth:
Date of Insertion:

Dear

Your patient has been in our office and received his/her oral appliance to address his/her condition of Obstructive Sleep Apnea to complete the first phase of oral appliance therapy through our program.

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.

Patient has reported subjective relief of symptoms, and was informed of the importance of post insertion sleep study with an oral appliance for efficacy.

Please contact the above named patient for a follow-up appointment and correspond any further recommendations to our practice.

Please fax all results of the post insertion PSG/HST to .

Sincerely yours,

_____