Herman Ostrow School of Dentistry of USC
Orofacial Pain and Oral Medicine Center
Oral Appliance Referral Form for
Medically diagnosed Obstructive Sleep Apnea
(Treatment order and medical necessity)

For making an appointment, please use our email address: **ofpomctr@usc.edu**
For calling our front desk: **213.740.3410**
For sending reports to our clinic, please use our fax: **213.821.7870**
Our website is available for additional information: **https://ofpomcenter.usc.edu**

Patient Name:
Date of Birth:

Diagnosis (select all that apply):

- ☐ Obstructive Sleep Apnea
- ☐ Hypersomnia due to Sleep Apnea
- ☐ Insomnia due to Sleep Apnea
- ☐ Sleep Apnea (Unspecified)
- ☐ Narcolepsy
- ☐ Restless leg syndrome
- ☐ Other

Treatment orders (select all that apply):

- ☐ Evaluate and treat
- ☐ Send a report (patient consent is required)
- ☐ Mandibular Advancement Device (MAD) (new or replacement)
- ☐ Mandibular Advancement Device (MAD) (Follow-up or adjustment)
- ☐ Other

Medical justification (select all that apply):

- ☐ Patient has tried CPAP and has not tolerated and/or complied with treatment.
- ☐ Unable to tolerate mask/straps
- ☐ Skin sensitivity
- ☐ Claustrophobia
- ☐ Mild OSA which will be managed with MAD therapy
- ☐ Other

Due to the history and examination, I recommend oral appliance therapy for the treatment of this patient. I, the undersigned, certify that the procedure prescribed above is medically necessary to the treatment of this sleep disorder.

Date

Referring Physician:

Physician's Signature (Initials if digital):