Patient Referral for
Oral Appliance for Sleep Apnea

Frank L. Angus DDS   Alexander T. Vaughan DDS

Date: ____________________

Patient's Name: ______________________________ Sex ☐M ☐F Birth Date: ______________

Address: ____

Home Phone: ______________ Cell Phone: ______________ SSN# ______________

Insurance #1 ______________________ Insurance #2 ______________________

Referring Physician Name: ______________________________ PCP? ☐Y ☐N

Office Telephone: ______________________ Fax: ______________________

Contact Name: ____

Appointment Date/Time: ______________________ Sleep Packet given? ☐Y ☐N

If a H&P Containing this information is not available, Please check the following

History of:

- ☐ Hypersomnia
- ☐ Insomnia
- ☐ Stroke
- ☐ Excessive daytime sleepiness
- ☐ Recent mood or cognition changes
- ☐ CPAP Intolerant
- ☐ Other
- ☐ Cardiac arrhythmia
- ☐ Cardiovascular disease
- ☐ Morning headache
- ☐ Hypnogogic hallucinations
- ☐ Sleep paralysis
- ☐ Depression and/or anxiety
- ☐ Hypertension
- ☐ Snoring
- ☐ COPD
- ☐ Diabetes
- ☐ Obesity
- ☐ Weight gain

Physical Exam: Wt: ______________ Ht: ______________ BP: ______________

ENT findings: ☐ Crowded oropharynx ☐ Tonsillar hypertrophy ☐ Enlarged soft palate/uvula

☐ Other ______________________________

☐ No significant ENT findings

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It's time to get some rest.