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Dr. Fernanda Almeida
DDS, MSc, PhD
Dental Sleep Medicine

Patient: ____________________

DOB: ______ / ______ / ______ Phone: (______) ____________

■ DIAGNOSIS: (Please check)

[ ] Snorer
[ ] Suspected Obstructive Sleep Apnea
[ ] Obstructive Sleep Apnea
[ ] UARS
[ ] Failed Upper Airway Surgery
[ ] Insomnia
[ ] Restless Leg Syndrome or PLM
[ ] Fibromyalgia
[ ] Narcolepsy
[ ] Other: ____________

■ MEDICAL JUSTIFICATION: Patient has attempted CPAP and has not complied for the following reason(s):

[ ] Unable to tolerate Mask
[ ] Chronic Sinus
[ ] Dermatitis
[ ] High CPAP pressure
[ ] Patient may benefit from combination: CPAP + Oral Appliance
[ ] Other: ____________

■ REFERRAL FOR:

[ ] Oral appliance for the treatment of OSA/UARS/Snoring
[ ] Other: ____________

Due to the above noted history I am recommending a consult for an evaluation of Oral Appliance Therapy for this patient.

Referring Doctor: ____________ Phone: ____________

Signature: ____________ Date: ______ / ______ / ______

Please Fax or email this form with a copy of the PSG/oximetry to
Fax: 604-732-5311 - email: info@vancouverwestdental.ca