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

Patient: _____

DOB: _____ / _____ / _____ Phone: (_____) _____

DIAGNOSIS: (Please check)

- ☐ Snorer
- ☐ Obstructive Sleep Apnea
- ☐ UARS
- ☐ Failed Upper Airway Surgery
- ☐ Insomnia
- ☐ Restless Leg Syndrome
- ☐ 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 and physical information I am recommending an Oral appliance for the treatment of this patient. I, the undersigned certify the above prescribed procedure is medically necessary in the treatment of this diagnosis.

Referring Physician: _____ 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