REFERRAL FORM FROM CLINIC

REFERRAL DATE: ___________________________

FROM FACILITY: ___________________________________ **PHONE#:** ____________________ **FAX #:** _____________________

REFERRING PHYSICIAN: _____________________________ **SPECIALTY:** __________________ **NPI #:** ___________________

PATIENT INFORMATION:

PATIENT NAME: ____ PHONE #: ______________________________________

ADDRESS: ____ EMAIL: _______________________________________

____ MALE ____ FEMALE DOB: ______________________

MEDICAL INSURANCE INFORMATION: (Attach photo of front and back if available)

SUBSCRIBER INFORMATION: ____ DOB: ____________

INSURED COMPANY NAME: ____ INS CO PHONE#: _________________________

SUBSCRIBER ID: _______________________________________ GROUP #: _________________________________

SYMPTOMS

____ FATIGUE/DAYTIME SLEEPINESS
____ WITNESSED APNEA
____ CHOKING/GASPING FOR AIR
____ OBESITY
____ SNORING
____ OTHER: ____
____ JAW PAIN
____ HEADACHES
____ NECKACHES
____ BRUXISM
____ DEPRESSION
____ RINGING IN EARS/EAR PAIN
____ WEARS CPAP/INTOLERANT
____ LOSS OF ENERGY
____ ASTHMA
____ RESTRICTED AIRWAY

ORDER/REQUEST:

____ EVALUATION FOR TMD/TMJ WITH CLINICAL EXAMINATION
____ PATIENT HAS BEEN DIAGNOSED WITH TMD/TMJ, BUT CURRENT APPLIANCE/THERAPY IS INEFFECTIVE
____ EVALUATION FOR POSSIBLE SLEEP BREATHING DISORDERS AND SLEEP STUDY REFERRAL
____ PATIENT HAS CPAP/BIPAP, BUT IS INTOLERANT**
____ PATIENT HAS BEEN DIAGNOSED WITH OBSTRUCTIVE SLEEP APNEA OR SIMPLE SNORING BUT NEVER TREATED**

*****INCLUDE PATIENT MOST RECENT SLEEP STUDY & PRESCRIPTION FOR MANDIBULAR ADVANCEMENT DEVICE THERAPY*****

PHYSICIAN SIGNATURE: ____ **DATE:** _________________________

DR MITCH CONDITT 451 University Dr. Ste 102 Fort Worth, TX 76107 PHONE#817-527-8500 ***REFERRAL FAX# 817-527-8512***