Patient Referral Form

Please fax this form with pertinent information to ***Fax # 816-527-9219.***

Patient Name:______________________________________ Age:__________

Responsible Party: ____

Best Phone: _________________________ Alt. Phone: ___________________

Patient Email: ____

Medical Insurance Carrier(s): ______________________________________

Reason for Referral:

_____ Sleep Apnea _____ TMJ Disorder _____ 3D Cone Beam

If Sleep Apnea Referral, please also Fax:

- Baseline Sleep Study with Diagnosis
- Chart Notes where sleep study results were discussed
- If patient is PAP intolerant, reason for intolerance
- Physician's Order for Oral Appliance (DME item)

Comments: ____

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Referring Doctor:

Name:____ Date:___________

Address: ____

City: _____________________________ State: _________ Zip:___________

Phone: ____

NPI Number: ____

Thank you for your referral. Our office will contact your patient for a consultation and keep you informed of their treatment progress.

Bill Busch, DDS
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