



Patient Referral Form

Please fax this form with pertinent information to **Fax # 765-250-9416**.

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: _____

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.

Shane Cope, DDS

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