Koala CenterForSleep&TMJDisorders

Patient Referral Form

Please fax this form with pertinent information to ***Fax #855-846-1768***

Patient Name:_____ DOB:_____

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 Chart Notes Related to Sleep Apnea including:

- Baseline Sleep Study with Diagnosis and Interpretation
- Face to Face Encounter Notes *Before and After* Sleep Study Order
- If PAP Intolerant, Therapy Attempts and Reasons for Intolerance
- A Detailed Written Order/Rx for Mandibular Repositioning Device (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.

Rod Willey, DDS, D.ASBA, D.ACSDD
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