Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB (dd/mm/yy):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐ **Primary Snoring**

**Obstructive Sleep Apnea:**  ☐Mild ☐Moderate ☐Severe

**If Severe:**

☐Tried and Failed CPAP: Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

☐Refuses CPAP: Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please send this form**, along with a copy of **the sleep study and diagnostic interpretation**   
via e-mail : [info@WestCoastDentalSleep.com](about:blank) or fax to 604 357 1785

**Occupational Risk**

☐ Peace Officer ☐ Paramedic ☐ Pilot ☐ Commercial Driver

☐ Search and Rescue ☐ Other

**Comorbidities**

☐ Hypertension ☐ Cardiac Disease ☐ Diabetes ☐ Anxiety

☐ Depression ☐ Respiratory Disease ☐ Other

Obstructive Sleep Apnea and Mandibular Advancement Device RX and Statement of Medical Necessity

The above-named patient has been diagnosed with Obstructive Sleep Apnea. I am prescribing a Precision Mandibular Advancement Device that meets or exceeds the standard guidelines for oral appliance design requirements. The device is for the treatment of the patient’s Sleep Apnea and length of need is lifetime; it is NOT for a dental disorder; it is durable medical equipment; and it is Medically Necessary.

Physician Name

Physician Signature

Date (dd/mm/yyy)

Office Stamp