The Sleep Apnea
CENTER OF CONNECTICUT

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Date:_____

Patient Name: _____

Patient Phone: _____

Referring Doctor: _____

Referring Dr's Phone: _____

Patient is being referred for an evaluation for Oral Appliance Therapy

HST / PSG Date: _____

Diagnosis: ☐ OSA ☐ Mild ☐ Moderate ☐ Severe

Patient currently uses a CPAP: ☐ Yes ☐ Yes ☐ NoNo

Patient declined CPAP or is CPAP intolerant: ☐ Yes ☐ No

Comments: _____

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