Virginia Sleep & TMJ Therapy
VSTT
AT STONY POINT

Patient Referral for **Oral Appliance Therapy**

Rebecca Angus DDS Frank L. Angus DDS
Jessica Vellucci, DDS

Contact Information:

Patient's Name: _____ Birth Date: _____

Home Phone: _____ Cell Phone: _____

Please attach supporting documents if available:
Patient insurance information, *Diagnostic sleep study results* and *Medical history*

Patient Diagnosis:

☐ G47.33 Obstructive Sleep Apnea, AHI/RDI: _____

☐ R06.83 Snoring

☐ Hypertension

☐ Excessive Daytime Sleepiness

☐ CPAP Intolerance

☐ Insomnia

☐ Other: _____

☐ Patient is referred for evaluation and treatment with an oral sleep appliance (E0486) as indicated to manage their snoring or obstructive sleep apnea.

Referring Physician Name: _____

Referring Physician Signature: _____

Office Telephone: _____ Fax: _____

8730 Stony Point Pkwy, Suite 240 / Richmond, VA 23235
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Online Patient Registration

It's time to get some rest.