P: 512-215-4350
F: 512-647-6367

Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea (OSA)*

Referring Physician _____ Tel: _____

Patient Name _____ DOB: _____

Patient Address _____

Patient Telephone _____

Please include patient demographics, insurance, appointment notes, and sleep study (if the patient has one).

Prescription to be filled by:

☐ Sleep Better Austin - South
5920 W. William Cannon Dr., Bldg #6, Ste. 200
Austin, TX 78749

☐ Sleep Better Austin - Cedar Park
920 N. Vista Ridge Blvd., Ste. 700
Cedar Park. TX 78613

☐ Sleep Better Austin - Central
The Jefferson, 1600 W. 38th St., Suite 407
Austin, TX 78731

☐ Sleep Better Austin - Georgetown
4405 Williams Dr., Ste. 300
Georgetown TX 78628

The patient referred with this form has been evaluated by the above physician and has been diagnosed using acceptable medical criteria to have:

☐ Obstructive Sleep Apnea
-or-
☐ Simple Snoring
-or-
☐ Patient Needs Sleep Study

Severity: _____

This patient is:

☐ Intolerant of C-PAP therapy ☐ Is not a candidate for C-PAP therapy

Notes: _____

_____

_____

Signature of Referring Physician: _____

DR. NPI # _____

Date: _____ *As a physician, I deem this therapy to be medically necessary.*

Please fill out this prescription in its entirety.

*Obstructive Sleep Apnea Is a medical condition that tends to become more severe with time and requires periodic re-evaluation by a qualified physician.