



Northland Dental Choice

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Dr. Sean Andrew Tsandelis

DMD, BSc
Dental Sleep Medicine

Sleep Consult and Recommendation for Oral Appliance Therapy

Patient Information

Patient Name: _____ DOB: _____ Gender: _____

Phone #: _____ Email: _____

Address: _____ City: _____ Postal Code: _____

Reason for Referral: Screening for Sleep Disordered Breathing
 Oral Appliance for the Treatment of OSA/UARS/Primary Snoring

Diagnosis (if applicable)

Snorer UARS Insomnia
 Suspected Obstructive Sleep Apnea Failed Upper Airway Surgery Fibromyalgia
 Obstructive Sleep Apnea Mild / Moderate / Severe Restless Leg Syndrome or PLM Narcolepsy
 Other, please explain: _____

**Please include diagnostic sleep study and interpretation with referral (if applicable)*

CPAP History

Has the patient tried CPAP? Yes No

If yes, reason for intolerance:

Unable to tolerate mask High CPAP pressure
 Chronic sinus issues Patient may benefit from combination: CPAP + Oral Appliance
 Skin irritation/Dermatitis Other: _____

Referring Provider

Referring Doctor: _____ Phone #: _____

Signature: _____ Date: _____

Additional Comments: _____