PHYSICIAN Rx FORM

Patient is a suitable candidate for a SomnoMed Oral Device

PATIENT INFORMATION

PATIENT NAME | DATE OF BIRTH | GENDER

PHONE (PRIMARY) | PHONE (SECONDARY)

ADDRESS

CITY | STATE | ZIP/POSTAL CODE

MEDICAL JUSTIFICATION (mark all that apply)

- ☐ Unable to tolerate CPAP
- ☐ Patient prefers Oral Device after discussing options

RECOMMENDED THERAPY (mark all that apply)

- ☐ SomnoMed Oral Device
- ☐ Follow-up with Sleep Physician after Oral Device titration is complete
- ☐ Arrange a Sleep Study (☐HST ☐PSG) with my office prior to follow-up

REFERRING PHYSICIAN

PHYSICIAN NAME (Printed)

PHONE | FAX

SIGNATURE | DATE | NPI

PHYSICIAN RX FORM 903106 revA

www.somnomed.com
7460 Warren Parkway, Suite 190, Frisco, TX 75034

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