# COAT™ Rx

***(Continuous Open Airway Therapy)***

Patient is a suitable candidate for a SomnoMed Oral Device

## *PATIENT INFORMATION*

| PATIENT NAME | | | DOB | GENDER |
|---|---|---|---|---|
| ADDRESS | | CITY | STATE | ZIP/POSTAL CODE |
| PHONE | EMAIL ADDRESS | | EMPLOYER | |

## *INSURANCE INFORMATION* (or attach face sheet)

*PRIMARY INSURANCE COMPANY*

## *DIAGNOSIS INFORMATION*

☐ Obstructive Sleep Apnea 327.23
Please include the Sleep Study with this Rx form.

## *RECOMMENDED THERAPY* (mark all that apply)

☐ SomnoMed Oral Device (E0486) ☐ Compliance Recorder

☐ Follow-up with Sleep Physician after Oral Device calibration is complete

☐ Arrange a Sleep Study (☐HST ☐PSG) with my office prior to follow-up

## *REFERRING PHYSICIAN*

| PHYSICIAN NAME (Printed) | SERIAL # ON DENTITRAC BASE STATION |
|---|---|
| SIGNATURE | DATE |
| PHONE | FAX |
| PREFERRED DENTIST | |

**Attn. Dentist: Please attach this form to the SomnoDent® order form.**

PHYSICIAN RX FORM 903106 revC

*www.somnomed.com*
*Main: 888.447.6673*
*Toll free e-fax: 866.422.6491*
*7460 Warren Parkway, Suite 190, Frisco, TX 75034*

SomnoMed®
*The Leader In COAT™*
*(Continuous Open Airway Therapy)*