Alexander H Malick, DMD, FAGD
1899 E. Roseville Parkway, Suite 160   Roseville, CA 95661
_V: (916) 787-1199   F (916) 787-0400_
mydentist160@gmail.com

Referral form for Snoring/Obstructive Sleep Apnea

_Patient: ___________________________________ Date of Birth: __________________________

_Patient Address: ____

_Medical Insurance Co. _______________________________ ID: __________________________
_

_Dental Insurance Co. ________________________________ ID: __________________________
_

_Referring Physician: ____
_

_Office Phone: v:____________________________ f: __________________________
_

_Latest Sleep Study date: _________________________ OSA: (circle) mild moderate severe_

Has patient attempted CPAP: yes no

Documents needed:

1. _Physician Referral, signed and dated_
2. _Patient demographics_
3. _Attending physician's notes, specifically stating medical necessity for oral device_
4. _Copy of the sleep study report_
5. _Notes documenting CPAP intolerance._

____ ____________________________
Referring physician's signature _date_