

SNORING AND SLEEP APNEA

DENTAL TREATMENT CENTER

Site Accredited by American Academy of Dental Sleep Medicine

11313 Ash Street • Leawood, Kansas 66211 • p: 913-451-2929 • f: 913-451-2959
www.kcsleepapneadentist.com • info@kcsleepapneadentist.com

Prescription to be filled by:

Dr. Nancy Addy, D.D.S.

Diplomate of American Board
of Dental Sleep Medicine

Dr. Jarrett Grosdidier, D.D.S.

Diplomate of American Board
of Dental Sleep Medicine

Physician _____ Telephone _____

Patient Name _____ DOB _____

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

___ Obstructive Sleep Apnea (G47.33): Mild ___ Moderate ___ Severe ___

___ Simple Snoring

___ Other, please specify _____

The patient is:

___ CPAP intolerant

___ Not a candidate for CPAP therapy

___ Other: Explanation _____

As a physician, I deem this therapy to be medically necessary. Patient is being referred for:

___ Mandibular Advancement Device (E0486)

___ Mouth Closing Device for use with CPAP

___ Home Screening / Calibration

Physician Signature _____ Date _____

Obstructive Sleep Apnea is a medical condition that tends to become more
severe with time and requires continued follow up by a qualified physician.

Date of diagnostic sleep study _____

For appropriate care, Drs. Addy and Grosdidier require a copy of the diagnostic sleep study.
PLEASE FAX THE PATIENT'S DIAGNOSTIC SLEEP STUDY AND THIS FORM TO 913-451-2959

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