DR. LES PRIEMER
SNORING AND SLEEP APNEA THERAPY

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REFERRAL FORM

PATIENT INFORMATION

Patient Name: _____

Phone Number: (Tel) _____ (Cell) _____

E-Mail: _____

REQUESTING DOCTOR

Name: _____

E-mail: _____ Phone: _____

Diagnostic Sleep Study Available?: ☐ Yes ☐ No (If Yes, please forward by fax or email)

Reason for Referral: _____

_____

☐ Sleep Apnea ☐ Upper Airway Resistance Syndrome ☐ Snoring

☐ Bruxism ☐ TMD Therapy

Therapies Attempted: _____

_____

Rx: ☐ Fabricate Custom Oral Appliance

Doctor's Signature: _____