Oral Appliance Therapy Referral Form for treatment of
Sleep Breathing Disorder with Mandibular Advancement Splint (MAS)

Referral to: **Dr Elaine Ng**
My Dental Team
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Royal Square Medical Centre
Singapore 329565
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Email: yoursmile.novena@mydentalteam.sg

Patient's Information
Full name:_____
DOB:_____
Address:_____
Phone:_____
Email:_____

Sleep Study Available: Y/N (circle)
If baseline sleep study has been conducted please attach report*

Reason For Referral Diagnosis: (tick relevant items)
- ☐ Snoring (ICSD R06.83)
- ☐ Obstructive sleep apnoea (ICSD G47.33)
- ☐ Sleep apnoea/Sleep related breathing disorder, Unspecified (ICSD 327.20)
- ☐ Hypersomnia due to Sleep apnoea(ICSD 780.53)
- ☐ Unspecified (ICSD 780.57)

Sleep Study Data :
AHI:_____ RDI: _____ Lowest desaturation SpO2 %:_____
Current or past treatment
Surgery : Y/N (circle) Surgery type and date:_____
CPAP : intolerant/not good candidate/occasional use/declined use (circle)
Other relevant information:_____
_____

Statement of medical necessity
The above patient has been assessed by myself and has undergone a sleep study for sleep related breathing disorder. This evaluation confirmed the diagnosis of primary snoring/upper airway resistance syndrome(UARS)/obstructive sleep apnoea.

Oral appliance therapy is accepted first line therapy for primary snoring, UARS and mild-moderate OSA, and severe OSA patients who are intolerant of other treatment. A mandibular advancement device is medically necessary for this patient and I am referring to Dr Elaine Ng for evaluation and management with oral appliance therapy.

Referring Physician:_____ Email:_____

Physician's Signature:_____ Date:_____