Superior Sleep and Wellness

Referral for Oral Appliance Therapy for Obstructive Sleep Apnea or Simple Snoring

** This form is for patients that are being referred to Superior Sleep and Wellness for evaluation. If the patient has recently been diagnosed with obstructive sleep apnea through a sleep test, or if the patient has received a sleep test denying the presence of sleep apnea but desires treatment for simple snoring, please fill out the prescription form instead.*

Name of Physician (Print): _____ Tel: _____

Patient Name: _____ Patient DOB: _____

Patient Address: _____

Patient Phone: _____ Patient Email: _____

Patient Insurance: _____ Insurance Phone: _____

** Please fax a copy of the patient's medical insurance card with this referral form.*

Referred to:
Dr. Frank Holecek
Superior Sleep and Wellness LLC
2510 South Rochester Road Suite B
Rochester Hills, MI 48307
P: (248) 844-1415
F: (248) 844-1864

The patient referred with this form has been evaluated by the above physician and is in need of further evaluation for:

☐ G47.33 Obstructive Sleep Apnea ☐ Simple Snoring Severity: _____

Explanation (if necessary): _____

_____

Notes: _____

_____

_____

Signature of Referring Physician: _____

Date: _____

* Obstructive Sleep Apnea is a medical condition that tends to become more severe with time and requires periodic re-evaluation by a qualified physician. Oral Appliance Therapy (OAT) is less effective in controlling severe sleep apnea than C-PAP, and patient referred for this therapy may need to explore additional options of treatment if the appliance alone is deemed to provide suboptimal management of the sleep apnea. Copies of sleep studies with full report are required by Dr. Holecek for appropriate care and to obtain medical coverage.