sleep better maryland
SLEEP APNEA| TMJ | HEADACHE TREATMENT

12620 State Route 108 (Clarksville Pike)
Clarksville, MD 21029-1532
(410) 531-5639
(443) 535-6863 fax
www.SleepBetterMaryland.com
www.ParmarDMD.com

Rashmi K. Parmar, DMD, DABDSM

Sleep Apnea and TMD Patient Referral Form

Patient's Name: _____ Date of Birth: _____ M / F

Phone Numbers: Home: _____ Work: _____ Cell: _____

Insurance Co: _____ Policy No.: _____ Policy Holder: _____

□ Please contact Patient □ Patient will contact the office □ Please call the referring Doctor

FAX THIS WITH MOST RECENT DOCTOR'S NOTES TO: (443) 535-6863

Obstructive Sleep Apnea

□ PSG Performed Date: _____ □ Copy Enclosed

□ Other services performed: _____

Diagnosis

□ Obstructive Sleep Apnea ICD 327.23 □ Primary Snoring ICD 786.09
□ Mild □ Moderate □ Severe

□ Other _____

Treatment History

□ CPAP Titration study performed Date: □ Copy enclosed
CPAP Pressure: Cm H_20 □ On O_2

Surgical Procedures

□ Tonsils/adenoidectomy Date: _____ □ Pillar procedure Date: _____

□ Uvulopalatopharyngoplasty Date: _____ □ Nasal/airway surgery Date: _____

□ Other: _____

Referral for Oral Appliance Therapy Consultation, Evaluation and Treatment

□ CPAP intolerance
□ Adjunct to CPAP therapy
□ Refusal of CPAP titration study
□ Refusal to wear CPAP machine
□ Mild to moderate OSA
□ Primary snoring
□ Inadequate surgical outcome
□ Other: _____

□ R_x consultation, evaluation and treatment for oral appliance treatment

Treatment duration will be at least six months, unless other interventions such as surgery occur and could well be required for the remainder of your subscriber's life. ORAL APPLIANCE is used in conjunction with or as an alternative to surgery and or CPAP.

Referring Physician's Signature: _____ Date: _____ Phone No.: _____

TMJ/TMD Referral

Patient's chief complaint(s): *Please check all that apply*

□ TMJ Pain / soreness
□ TMJ Clicking, popping, grating noise
□ Headaches
□ Migraines
□ Neck and shoulder pain
□ Ear pain or stuffiness
□ Vertigo / dizziness
□ Tinnitus / ringing
□ Limited mouth opening
□ Pain on opening or closing
□ Change in bite / uncomfortable bite
□ Unexplained facial or tooth pain
□ History of trauma
□ Other _____

□ R_x consultation, evaluation and treatment for TMD/TMJ treatment Referring Physician's Signature: _____ Date: _____ Phone No.: _____