DR. GARY M. RADZ

Prescription for Oral Appliance Therapy

To: Dr. Gary Radz, DDS

Patient Name:_____ DOB:____/____/_____

I am writing to inform you that it is medically necessary for the above patient to be fitted for an oral appliance (Mandibular Advancement Device)

This Patient:

___ Was Diagnosed with Obstructive Sleep Apnea (ICD-code 327.23)
___Mild ___Moderate ___Severe

___ Was not diagnosed with sleep apnea, but due to some disordered breathing, I have suggested an oral appliance for mandibular repositioning.

This Patient:

___ Is intolerant of CPAP therapy

___ Is not a candidate for CPAP therapy

Explanation (if necessary);_____

___ Requires combination therapy, adding a mandibular advancement device with their CPAP machine

___ Was advised CPAP was the gold standard, but still requests a mandibular advancement device

Physician Signature:

Sign: _____ Date: _____ Phone: _____

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