ward
PERIODONTICS & IMPLANTS

Audra Ward DMD, MS

DENTAL SLEEP MEDICINE REFERRAL FORM

Date _____

Patient's Name _____

Phone _____ DOB _____

REASON FOR REFERRAL

___ Comprehensive Dental Sleep Medicine Exam

___ Home Sleep Testing (HST)

___ Oral Appliance Therapy

Other _____

COMPLAINTS / SYMPTOMS *(check all that apply)*

___Snoring ___Daytime Sleepiness ___Morning Headaches
___Witnessed Apnea(s) ___ Difficulty Sleeping ___Non-refreshing Sleep ___Teeth Grinding

Other _____

REFERRING DENTIST/PHYSICIAN

Referring Dentist/Physician Name

_____

Office Contact _____

Phone _____ Fax _____

COMMENTS

_____

_____

_____

Please send sleep testing interpretation, if applicable.

12701 Metcalf Avenue, Suite 200 | Overland Park, KS 66213
P 913 563 7400 | F 913 563 7402 | wardperio.com