# OAT PATIENT COORDINATION FORM

## PATIENT/PROVIDER INFORMATION

### PATIENT

- **Name:** _____ **DOB:** ____ / ____ / ____
- **Address:** _____
- **Phone #:** _____

### MEDICAL PROVIDER

- **Name:** _____ **NPI:** _____
- **Address:** _____
- **Phone #:** _____

### DENTAL PROVIDER

- **Name:** _____ **NPI:** _____
- **Address:** _____
- **Phone #:** _____

# MEDICAL PROVIDER → DENTAL PROVIDER

| SLEEP HISTORY | |
|---|---|
| Symptoms | |
| Co-morbidities | |
| Baseline ESS (or other scaled score) | |

| SLEEP STUDY | |
|---|---|
| Type of Sleep Study | HSAT _____ PSG _____ |
| Date of Sleep Study | _____/_____/_____ |
| Baseline Study Results | AHI _____ RDI _____<br>Oxygen Desaturation Nadir _____ |
| Sleep Study Report Attached | Y / N |

| DIAGNOSIS, THERAPY | |
|---|---|
| SDB Diagnosis | Primary Snoring _____<br>Mild /Mod /Severe OSA _____<br>Other _____ |
| CPAP Therapy Attempted | Y / N, If yes, reason for discontinuation: |
| Other Therapies Attempted | |

## REFERRAL, TREATMENT GOALS

| | |
|---|---|
| Reason for Referral to Dental Provider | Consult for MAD _____<br>Initiate MAD _____<br>Evaluate current MAD for adjustment/repair _____<br>Fabricate new MAD _____<br>Combination therapy _____ |
| Target Sleep Study Values | AHI _____ RDI _____<br>Oxygen Desaturation Nadir _____ |
| Target Clinical Symptom Reduction | Snoring _____ Sleepiness _____<br>Fatigue _____<br>Non-restorative sleep _____<br>Other _____ |

## SPECIAL CONCERNS/NOTES FOR DENTAL PROVIDER

# PRESCRIPTION AND MEDICAL NECESSITY

**Patient Name: _____ DOB: ____ / _____/ _____**

**_____ I am prescribing a Mandibular Advancement Device (E0486) and Morning Re-positioner for the above-named patient.**

**_____ Medical Necessity: I am writing to inform you that it is medically necessary for the above-named patient to be fitted for a mandibular advancement device (E0486).**

**Prescriber Name: _____ NPI: _____**

**Prescriber Signature: _____Date: _____**

# DENTAL PROVIDER → MEDICAL PROVIDER

| FINANCIAL | |
|---|---|
| Insurance Accepted | Y / N<br>If yes, list insurances accepted:<br><br>If no, list out of pocket cost: $ |
| Accommodations for MAD Breakage/Malfunction or MAD Warranty | |

| MANDIBULAR ADVANCEMENT DEVICE (MAD) | |
|---|---|
| Name/Type of MAD | |
| MAD Calibration Data Collection Method | |
| MAD Calibration Instructions (or attach) | |
| Final MAD Assessment Position | Single _____ Adjustment _____<br>Adjustment Instructions (or attach): |
| Post MAD Assessment Patient Instructions | Return MAD to pre-study position and f/u with Dental Provider _____<br><br>Keep MAD in post-study position and f/u with Dental Provider _____ |