Planken Integrative Wellness Inc.

breathe • nourish • sleep • smile

ORAL APPLIANCE RX & ORDER FORM

Patient Information

Patient Name:_____ Date of Birth:_____

Phone:_____ ☐M ☐F Height: _____Weight: _____

Medical History

☐ Excessive Daytime Sleepiness
☐ Hypertension
☐ CHF/Cardio myopathy
☐ GERD
☐ Impaired Cognition
☐ Ischemic Heart Disease
☐ Atrial Fibrillation
☐ COPD
☐ Mood Disorders
☐ History of Stroke
☐ Diabetes
☐ Other:_____

Check All that Apply

☐ Attempted CPAP
☐ Witnessed Apnea
☐ Discomfort caused by mask & headgear
☐ CPAP restricted movement during sleep
☐ Unconscious need to remove the apparatus during sleep
☐ CPAP Intolerant
☐ Mask Leaks
☐ Insomnia
☐ Inability to get a good mask fit
☐ Partner's sleep disturbed by noise of device
☐ Claustrophobic Associations
☐ Other: _____

Diagnosis

☐ Obstructive Sleep Apnea, Adult/Pedo (G47.33)
☐ Sleep Apnea, Unspecified (G47.30)
☐ Sleep Related Bruxism G47.63)
☐ Snoring (R06.83)

Statement of Medical Necessity

☐ The patient has undergone asleep study for sleep-disordered breathing, which confirmed a diagnosis of obstructive sleep apnea. Based on this evaluation, the use of an oral appliance (E0486/K1027) is deemed medically necessary for the treatment of obstructive sleep apnea to improve airway patency and alleviate associated symptoms.

☐ The patient was unable to tolerate CPAP; therefore, oral appliance therapy has been prescribed.

☐ CPAP Trial Duration:_____ days weeks months

Physician Information

Name: _____NPI: _____ Date: _____

Signature:_____Phone: _____ Fax: _____

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