



ADVANCED SLEEP TREATMENT
ORAL APPLIANCES - SLEEP EDUCATION

Phone: 301-439-8333
Fax: 301-439-4622

Prescription for:

Oral Appliance Therapy for Obstructive Sleep Apnea

Please fill out this form in its entirety.

Referring Physician: _____

Physician Phone: _____ NPI: _____

Patient Name: _____

Patient Phone: _____ Email: _____

**Please Fax Copy of Patient's Insurance Card With This Prescription*

Prescription to be filled by:

Advanced Sleep Treatment

Dr. Ekaterina Tomenko

10230 New Hampshire Ave.

Suite 330

Silver Spring, MD 20903

The patient with this form has been evaluated by the above physician and has been diagnosed using acceptable medical criteria to have: Obstructive Sleep Apnea Snoring

Severity: _____ Length of Need: Lifetime Other _____

This patient is: CPAP Intolerant Not a candidate for CPAP Therapy _____

Notes: _____

As a physician, I deem this therapy medically necessary.

Referring Physician Signature

Date