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SMILES IN THE PINES
LEJLA STREETS, DMD

Diplomate, American Board of Dental Sleep Medicine
Center for Airway and Functional Dentistry

Patient Referral	
Patient Full Name:	
Address:	
Phone Number (Home):	
Phone Number (Cell)	
Email:	
Date of Birth:	

Brief History

__ Patient has OSA and is CPAP intolerant
__ Patient: Hx of Snoring
__ Patent: Hx of Bruxism
__ AHI ____________________
__ Date of Last Sleep Study: _______
__ Rx of HST after OAT delivery

Medical History:

- ☐ Hypertension
- ☐ Stroke
- ☐ Heart Disease
- ☐ Diabetes
- ☐ GERD

Suggested Therapy Steps:

- ☐ Receive Precision Advancement Appliance - Mandibular Advancement Device
- ☐ Provide results back to referring Physician

Referring Physician: ______________________________ Phone: ______________________________

Signature: ____

Date: _________________________________