Referral for
Oral Sleep Appliance Consultation
to
Michael F. Hnat, D.M.D.
PROGRESSIVE DENTAL SOLUTIONS
Dental Sleep Medicine Facility
3055 Washington Road, Suite 303
McMurray, PA 15317
Phone: 724-942-5630 Fax: 724-942-5632

Patient Name: _____ DOB:_____

Patient Phone: _____

Referring Physician: _____ M.D. / D.O.

Office Address: _____

Office Phone: _____

Office Fax: _____

Physician Signature: _____ Date: _____

Patient referred to Michael F. Hnat, D.M.D. to be evaluated for oral appliance therapy (OAT) due to:

☐ Mild OSA ☐ Moderate OSA ☐ Severe OSA _____ ☐UARS
AHI: _____ RDI: _____

☐ CPAP Intolerance

☐ Primary Snoring

☐ Surgical Result Inadequate

☐ Adjunctive therapy to CPAP or Surgery

☐ Additional comments regarding patient's history of OSA therapy:

_____

- A copy of the following should be faxed to office prior to consult appointment:
  - the most recent **complete** diagnostic PSG (i.e., long report)
  - the summary CPAP trial PSG (if patient had one)
  - patient's insurance information
- Correspondence on patient's progress with OAT will be directed to physician at address/fax provided above.

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