

Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea (OSA)*

Refe	erring Physician:	Tel:
Pati	ent Name:	
Pati	ent Address:	
Pati	ent Telephone:	
*Plea	ase fax copy of patient's medical insurar	nce card with this prescription.
Prescription to be filled by:		
	Aragona Sleep Solutions Dr. Sal Aragona 37020 Garfield Road, Suite T3 Clinton Township, MI 48036	
The patient referred with this form has been evaluated by the above physician and has been diagnosed using acceptable medical criteria to have:		
	Obstructive Sleep Apnea	Severity:
	-or- Simple Snoring	Length of Need: Lifetime Other (Specify):
This patient is:		
	and the second s	■ Is not a candidate for C-PAP therapy
	Explanation (if necessary):	
Notes:		
•		
Signature of Referring Physician:		
Dat	θ:	As a physician, I deem this therapy to be medically necessary.

Please fill out this prescription in its entirety.

^{*}Obstructive Sleep Apnea is a medical condition that tends to become more severe with time and requires periodic re-evaluation by a qualified physician.