



Patient Referral Form

Oral Appliance Therapy for Sleep Apnea & Snoring

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10134 N Oracle Rd, #170, Oro Valley, AZ 85704

Phone: 520-848-3889 | Fax: 520-989-3134

Referring Provider

Name: _____ Phone: _____

Practice: _____ Fax: _____

Email: _____

Patient Information

Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Reason for Referral

- ☐ Diagnosed obstructive sleep apnea
- ☐ Suspected sleep apnea / snoring, not yet diagnosed
- ☐ CPAP intolerance - seeking an alternative treatment
- ☐ Other: _____

Please Send Any Available Records

- ☐ Diagnostic sleep study
- ☐ Prescription / order for oral appliance therapy
- ☐ Relevant office / chart notes
- ☐ None yet - please contact our office to coordinate

Please fax this form and any available records to 520-989-3134.

Additional Notes

Referring Provider Signature: _____ Date: _____

Thank you for referring your patient to Sleep Matters. We'll reach out to the patient promptly and keep you informed throughout their care.