Dr. Billie Adams
Peak Family Dentistry, LLC
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Member of
AASM
American Academy of
SLEEP MEDICINE™

Breathe Well... Sleep Well... Live Well!

Referral for Evaluation and Treatment

Patient Information

Name:____________________ DOB:____________________

Primary Phone:____________________ Alternative Phone:____________________

Purpose of Referral

☐ Sleep Apnea / Primary Snoring Appliance Assessment

☐ Bruxism

☐ CPAP Failure

☐ Hypoxemia

☐ Tooth Pain

☐ Craniofacial Pain

☐ Other ____________________

____

Referring Provider Information

I have referred the above patient for consultation and treatment.

Referring Provider's Name:____________________

Referring Provider's Signature:____________________

Phone:____________________ Fax:____________________

Address:____________________

Email:____________________

Items to Include for Medical Reimbursement

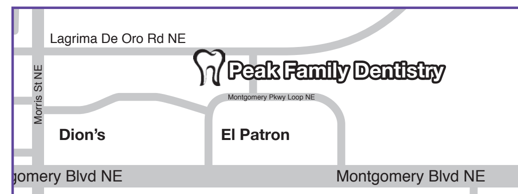
☐ PSG - Sleep Study Report (Diagnostic)

☐ Prescription from Physician

☐ Diagnostic Patient Chart Notes

Please fax this form and all above items to 505-293-0915 or email to info@peakfamilydentistryllc.com

A Connection to Continuous Open Airway Treatment for Sleep Apnea



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