CAROLINA
Dental Sleep Center

Shannon S McGee DDS, ABGD

TMD and Sleep Apnea Patient Referral Form

Patient's name: _____ Date: _____

Date of birth: _____ Phone number: _____

☐ Please contact patient ☐ Patient will contact your office

TMD Referral

Patient's chief complaint(s): (please check all that apply)

☐ TM joint pain
☐ TM joint clicking/joint sounds
☐ Headaches
☐ Migraines
☐ Neck/shoulder pain
☐ Ear pain
☐ Vertigo
☐ Tinnitus
☐ Eye pain
☐ Limited range of motion
☐ Pain on opening/closing
☐ Changes to bite/occlusion
☐ History of trauma
☐ Other:_____

Obstructive Sleep Apnea

☐ PSG Performed _____ Date ☐ Copy Enclosed

Diagnosis

☐ Obstructive Sleep Apnea ICD 327.23 ☐ Primary Snoring ICD 786.09

☐ Other: _____

Treatment History

☐ CPAP _____ Date of Initial Therapy CPAP pressure (if known) _____Cm H_2O ☐ On O_2

Surgical Procedures

☐ Tonsils/adenoidectomy Date: _____ ☐ Pillar procedure Date: _____

☐ Uvulopalatopharyngoplasty Date: _____ ☐ Nasal/airway surgery Date: _____

☐ Other: _____

Referral for oral appliance therapy evaluation for:

☐ CPAP intolerance
☐ Primary snoring
☐ Mild to moderate OSA
☐ Rx consultation/evaluation for oral appliance therapy
☐ Adjunct to CPAP therapy
☐ Inadequate surgical outcome
☐ Other:

Physician's Name: _____ Provider Number: _____

Physician's Signature: _____

Please fax completed form to 910-944-9334

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