Comprehensive Sleep Medicine Associates
CSMA
www.CSMA.CLINIC

THE WOODLANDS
3200 Research Forest Dr
Suite A-4
The Woodlands, TX 77381
(281) 297-6305 P
(281) 297-6436 F

HOUSTON MEDICAL CENTER
2201 W Holcombe Blvd.
Suite #330
Houston TX, 77030
(713) 668-4100 P
(713) 668-4105 F

SUGAR LAND
15423 Creek Bend Dr.
Suite A-1
Sugar Land, TX 77478
(281) 240-3773 P
(281) 239-6268 F

AUSTIN
8229 Shoal Creek Blvd.
Suite 101
Austin, TX 78757
(512) 691-7077 P
(512) 691-7080 F

BUSINESS OFFICE: 15423 CREEK BEND DRIVE, SUGAR LAND TX 77478

888-503-2762

JERALD H. SIMMONS, MD

DENTAL SLEEP REQUISITION FORM

REASON FOR REFERRAL

☐ New patient
- ☐ Suspected OSA
- ☐ Other: _____

☐ Established patient for follow up

☐ Sleep testing only (must supply the name of physician collaborating on the case to whom the results will be reported)
Collaborating physician: _____
Contact #: _____

ORAL APPLIANCE MANAGEMENT

☐ Possible oral appliance candidate
- ☐ Have patient return to our office for OAT
- ☐ Please refer patient to a dental office for OAT

☐ On oral appliance therapy (OAT)
Appliance Type _____ Advanced _____ mm
- ☐ Needs efficacy of OAT confirmed/tested
- ☐ Symptomatic despite maximal tolerable protrusion of OAT (possible combination therapy candidate)

☐ In need of letter of medical necessity for OAT.

IN-LABORATORY TESTING

☐ In-laboratory polysomnogram (PSG) requested
- ☐ Baseline/without treatment
- ☐ With OAT
- ☐ Other (specify): _____

HOME TESTING

☐ Home sleep apnea testing (HSAT) requested
- ☐ Baseline/without treatment
- ☐ With OAT
- ☐ Other (specify): _____

Assessments of Excessive Sleepiness: Epworth Sleepiness Scale Score _____

EXAM FINDINGS *(Optional)* Other _____

Height		Neck circumference		Chin press		Mandibular tori		Enlarged Tonsils	
Weight		Occlusion Class (1,2,3)		Chin press/tongue curl		Buccal abfractions		Micrognathic jaw	
BMI		Nasal obstruction		Freidman or Mallampati Score		Other bruxism / clenching signs		Scalloped tongue	
Cone beam CT findings:									

***** Note: If testing is ordered without consultation, the provider ordering the test will be required to obtain prior authorization, if required by the patient's insurance. Our office will obtain prior authorization if a CSMA provider performs a consultation prior to testing.

Presumed Diagnosis: _____
Brief History: _____

☐ Call back to discuss the case regardless of findings.

PLEASE PRINT:
Patient's Name (Last, First)
_____
Date of Birth (m/d/y): ____ /____/_____
Phone Numbers THREE if possible:
_____
Insurance: Name:_____
Policy#_____ Grp# _____

Date of request(m/d/y):____/_____/_____

Requesting Clinician: _____
Doctor's Office # _____
Doctor's Fax # _____