I am the local treating physician for the patient referenced below.

Dr. *(name of dentist)* has, at my request, provided an oral appliance to treat obstructive sleep apnea for our mutual patient whose date of birth is *(patient’s DOB)*.

I am requesting that Dr. *(name of dentist)* provide this patient with Level 3 home sleep apnea test equipment for follow-up purposes only, and forward the data to a Board Certified Sleep Physician for interpretation. I agree to review the test results and counsel the patient accordingly.

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*(local treating physician’s printed name) (local treating physician’s signature) Date*

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*(board-certified sleep physician’s printed name and address)*