6500 Busch Blvd
Suite 104
Columbus Ohio 43229

Monday to Thursday 7:30am-5:30pm
Friday 7:30am-11:30am
Office is closed from 12-1 for lunch

OHIO SLEEP TREATMENT LLC

(o)614.396.8286
(f)855.858.4924

Prescription for Oral Appliance Therapy for Obstructive Sleep Apnea (OSA)*

Referring Physician: _____ Tel: _____

Patient Name: _____

Patient Address: _____

Patient Telephone: _____

**Please fax copy of patient's medical insurance card with this prescription.*

Prescription to be filled by:

☐ **Ohio Sleep Treatment LLC**
Dr. Brandon Canfield
& Dr. Collin Emerick
6500 Busch Blvd.
Suite 104
Columbus, OH 43229

The patient referred with this form has been evaluated by the above physician and has been diagnosed using acceptable medical criteria to have:

☐ Obstructive Sleep Apnea
-or-
☐ Simple Snoring

Severity: _____

Length of Need: ☐ Lifetime
☐ Other (Specify): _____

This patient is:

☐ Intolerant of C-PAP therapy ☐ Is not a candidate for C-PAP therapy

Explanation (if necessary): _____

_____

Notes:

_____

_____

_____

Signature of Referring Physician: _____

Date: _____ *As a physician, I deem this therapy to be medically necessary.*

Please fill out this prescription in its entirety.

*Obstructive Sleep Apnea is a medical condition that tends to become more severe with time and requires periodic re-evaluation by a qualified physician.