RED ROCK
SLEEP & AIRWAY SOLUTIONS

Dr. Alan McCaffrey, DMD

Dental Sleep Medicine Referral Form

Date: _____

Patient's Name: _____

Phone: _____ DOB: _____

Referring Provider

Referring Provider Name: _____

Office Contact: _____ Email: _____

Phone: _____ Fax: _____

Reason for Referral

- ☐ Comprehensive Dental Sleep Medicine Exam
- ☐ Home Sleep Testing (HST)
- ☐ Oral Appliance
- ☐ Snore Appliance
- ☐ Other: _____

Complaints / Symptoms (check all that apply)

- ☐ Snoring
- ☐ Daytime Sleepiness
- ☐ Morning Headaches
- ☐ Witnessed Apnea(s)
- ☐ Difficulty Sleeping
- ☐ Non-refreshing Sleep
- ☐ Teeth Grinding
- ☐ Other: _____

Comments

_____

_____

_____

_____

Please send sleep testing interpretation, if available.

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