Dr. Dawn M. Rickert, DMD, MAGD, D.ABDSM

BUCKS COUNTY
Dental Sleep Medicine
& TMJ Therapy

REFERRAL FORM

Patient Name: _____

Date of Birth: _____

Referral for:

- ☐ Snoring
- ☐ OAT (Oral Appliance Therapy)
- ☐ Patient has been diagnosed with OSA — Mild ☐ Moderate ☐ Severe ☐
- ☐ Patient is CPAP intolerant/noncompliant
- ☐ Pediatric Airway/ Sleep Consult
- ☐ **TMJ** (Temporomandibular Joint Dysfunction)
- ☐ Other: _____

Referring Physician/ Dentist:

Date: _____

_____
PRINTED NAME

_____
NPI#

_____
SIGNATURE

PLEASE FAX CLINICAL NOTES AND SLEEP STUDIES TO: ***215. 862. 5230***

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