**Oral Appliance Therapy Initiation Letter to Dentist of Record**

*note: this template may be used to notify a patient’s dentist of record of oat initiation and to collect pertinent patient information.*

INSERT DATE

INSERT DENTIST NAME/ADDRESS

RE: INSERT PATIENT NAME AND DOB

Dear Dr. INSERT DENTIST NAME,

Our mutual patient was referred to me by INSERT REFERRER for oral appliance therapy (OAT) for obstructive sleep apnea (OSA).

Prior to OAT, it is important to verify that this patient has had a dental exam within the past six months, has no current dental infection and no anticipation of extensive restorative dental or orthodontic care within the next six months excluding filings. Please return the below form as soon as possible; it is an important part of our pretreatment patient evaluation.

To ensure you are informed of this patient’s care, I will routinely provide progress reports on their OAT including visits for long-term follow-up and management of side effects.

Should I find that this patient has any dental needs during our care, I will refer them back to you for any treatment you deem appropriate. I would greatly appreciate it if you would let me know of any side effects or concerns regarding OAT that this patient brings to your attention.

I would be happy to discuss our treatment protocol with you if you have any questions or concerns.

Sincerely,

INSERT DENTIST NAME

INSERT PRACTICE CONTACT INFORMATION

I certify that this patient:

* Has had a dental exam within the past six months
* Has no anticipation of extensive restorative dental or orthodontic care within the next six months
* Does not have a dental infection requiring treatment.

## Date of last dental exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dentist name (please print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Dentist signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If unable to verify these criteria, please describe any concerns you may have about this patient proceeding with oral appliance therapy for the treatment of obstructive sleep apnea:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please fax this letter to INSERT PRACTICE CONTACT INFO