SLEEP INSIGHTS DENTAL REFERRAL FORM

Kenneth Halliwell, MD, Medical Director
Board certified in Neurology and Sleep Medicine

2625 Delaware Avenue | Buffalo, NY 14216
p (716) 332.0404 | f (716) 871.1998| www.sleepinsights.com

7220 Porter Rd | Niagara Falls, NY 14304
p (716) 575.0075 | f (716) 242.0611| www.nnsleep.com

Last name	First name	MI
Phone	DOB	Sex: M F

___ **Evaluate and manage oral appliance for sleep apnea/snoring**

___ Other / Additional requests:

_____

_____

_____

_____

_____

Please attach the following:

1.) Relevant clinical notes
2.) Medication list
3.) Insurance card
4.) Demographic sheet

Practitioner's signature _____ Date _____

Practitioner's name (PRINT) _____ NPI # _____

Practice name _____ **Dental Practice Y N**