Green Mountain
DENTAL SLEEP CENTER
BETTER BREATHING. BETTER HEALTH.
206 North Main Street Rutland, VT 05701

REFERRAL FORM
Fax to 844.929.1134

Patient Name ______________________ DOB ______________

(H)______________ (W) ______________ (C) ______________
Patient Telephone

Primary Insurance Co. ______________ Secondary Insurance Co. ______________

Referring Physician ______________________

Physician Address ______________________

Physician Telephone ______________ Fax ______________

Reason for referral:

_______ Oral Appliance Therapy

_______ Snoring

_______ TMD

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Date of Last Polysomnography Test (attach copy to fax if possible)

Additional Comments:

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Referring Physician's Signature ______________________ Date ______________