Dentist Referral form for Oral Appliance Therapy

Should the patient require referral for oral appliance therapy from a dentist, please use this form.

Dr. Thomas Kimberly, DDS, Diplomate American Board of Dental Sleep Medicine

Clinic Name: TK Dental

Phone: (216) 464-3777

Address: 3700 Park East Drive #180, Beachwood, OH 44122

Fax: (216) 464-3377

Email: tkdentaldds@gmail.com

Website: www.tkdentaldds.com

Patient Name:	
Patient Phone #:	**DOB:** ______/______/______ **Age:** __________

Referring Dentist: **(Name and Phone #)**
Sleep Study: ◯ Yes, it is attached ◯ No, patient is an initial consultation
Reason for referral: ◯ Snoring ◯ Sleep Apnea ◯ Morning headaches ◯ Not tolerating CPAP ◯ Other ____

Additional Dentists Remarks:

Dentist Signature: ____ **Date:** ________________________________