DENTAL PROSTHETIC SERVICES
Sleep Appliance Rx

Doctor:______________________________
Phone: ______________________________
Address:______________________________
City/State/ZIP:__________________________

Patient:______________________________
Age: ❑ Youthful ❑ Middle-Age ❑ Mature
Gender: ❑ Female ❑ Male

Contact for case questions: ____
Contact email: ____________________________ Email can be used for case questions? ❑ Yes ❑ No
Special delivery instructions: ______________________________________

Deliver by 5:00pm on _________________

Select Appliance Type

❑ EMA® Custom

❑ OASYS™
  ❑ Tongue lifting buttons

❑ Panthera D-SAD™ *(please complete Panthera Rx)*

❑ TAP® 3

❑ dreamTAP™ *(Thermoblend)*

❑ dreamTAP™ DuraFit *(Thermoplastic)*

Trial Appliances (90 Day)

❑ EMA® First Step ❑ myTAP™

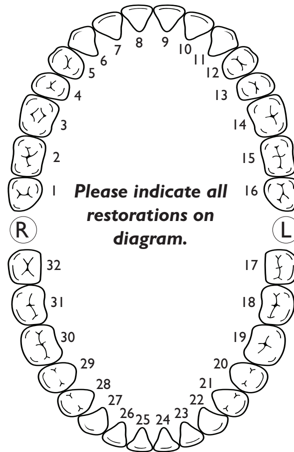
❑ SomnoDent™

Select SomnoDent body type
❑ Classic ❑ Fusion ❑ Herbst Advance

Select SomnoDent tray material
❑ Acrylic (ball clasps) ❑ Flex

Select SomnoDent options
❑ Anterior opening ❑ Bite ramp ❑ Elastics

❑ AM Reprogrammer *(included with appliances)*



Materials Enclosed

❑ PVS impressions
  ❑ Upper ❑ Lower

❑ Models *(Grade 4 stone recommended)*
  ❑ Upper ❑ Lower

❑ **Intraoral scans sent**
  System: __________________________

❑ Protrusive bite
  right ________mm or left ________mm

❑ I would like a phone call regarding instructions

Comments:

DENTAL PROSTHETIC SERVICES
1900 51st Street NE
Cedar Rapids, Iowa 52402
800-332-3341 • Fax 319-393-8455
www.DPSdental.com

Please send my office:
❑ **Rx Fixed** ❑ **Rx Sleep**
❑ **Rx Removable** ❑ **Rx Implants**
❑ **Rx Ortho** ❑ **Boxes**
❑ **UPS/Mailing Labels**

Doctor Signature: ______________________________
(Please select shade, age, gender, and delivery date)