DEVICE REQUEST FORM

ORDER A NEW DEVICE

Oventus Medical USA
c/o The UPS Store
227 Bellevue Way NE, PMB75
Bellevue, WA. 98004
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Phone: 844-780-5957
Fax : +61731803391

Patient name	
Date of birth	
Email address	
Clinician name	
Clinician Address	
Practice name	
Sleep Physician	
Date of order	

Oventus use only:

Device number:

Please note that a bite registration with 5mm vertical clearance (universally) is essential to incorporate the airway technology. In addition, upper and lower impressions that cover the entire arch (all tooth surfaces up to 5mm past the gingival margin), free from drag marks are required. This will ensure adequate fit and retention of the inserts. If the bite or impressions are not suitable, we will request new records which may delay the manufacture of the device.

Contents *(please tick)*

- ☐ Upper arch PVS impressions
- ☐ Lower arch PVS impressions
- ☐ Models
- ☐ Bite registration
- ☐ Digital Records - Send to scans@oventus.com.au

Information required:

- ☐ 5mm vertical clearance on bite registration posterior
- ☐ Facial midline marked on upper impression
- ☐ Jaw position: _____ % max advancement
- ☐ Bruxism: ☐ mild ☐ moderate ☐ severe ☐ n/a

Device request *(please tick)*

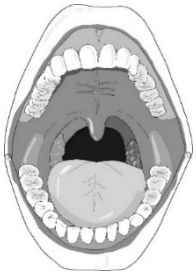
- ☐ O_2Vent Mono (Fixed Position)
- ☐ O_2Vent T: Titratable (Titration-Anterior Screw)
- ☐ O_2Vent W: Winged (Titration-Bilateral Extension Screws)

I hereby authorize the placing of this order on behalf of the Practice and the supply of the devices selected above in accordance with this Device Request Form.

_____ _____ _____

Authorised signature *Name* *Date*

Clinician comments/notes on anatomy**:**



Technician comments:

Sign: Date:

Oventus use only:

Date received: Date dispatched: Invoice number:

Impressions returned with device: Y / N