

# Home Sleep Test Order Form



**Submit order via FAX:  
(800) 260-7001**

**Patient Demographics:**

Name: \_\_\_\_\_ Sex: \_\_\_\_ DOB: \_\_\_\_\_ Soc Sec #(last 4 digits) \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_ Insurance ID# \_\_\_\_\_

**Presenting Symptoms:** *\*(Must have at least one checked off per Medicare Guidelines)*

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Sleep disordered breathing   | <input type="checkbox"/> Loud snoring          | <input type="checkbox"/> Insomnia      |
| <input type="checkbox"/> Excessive daytime somnolence | <input type="checkbox"/> Observed apnea        | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Awakening gasping for breath | <input type="checkbox"/> Non-restorative sleep | <input type="checkbox"/> Arrhythmia    |
| <input type="checkbox"/> Morning headaches            | <input type="checkbox"/> Morning dry mouth     | <input type="checkbox"/> Stroke        |
| <input type="checkbox"/> Mood Disorders               | <input type="checkbox"/> Cognitive Impairment  | <input type="checkbox"/> Hypertension  |

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Neck size: \_\_\_\_\_

Epworth Sleepiness Scale	Never would doze off	Slight Chance of dozing	Moderate Chance of dozing	High Chance of dozing
1. Do you get sleepy, or doze off, while sitting and reading?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
2. Do you get sleepy, or doze off, while watching TV?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
3. While sitting or inactive in a public place (meeting, Theater)?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
4. As a passenger in a car for an hour without a break?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
5. Lying down to rest in the afternoon?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
6. Sitting and talking to someone?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
7. Sitting quietly after lunch without alcohol?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>
8. In a car, while stopped for a few minutes at a traffic light?	0 <input type="checkbox"/>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>

**Total Score** (sum of all numbers checked above) Scores  $\geq 10$  suggest patient is at high risk for Obstructive Sleep Apnea.

**Suspected Diagnosis:** *\*( one must be checked)*

- G47.33 Obstructive Sleep Apnea     G47.14 Hypersomnia     G47.01 Insomnia/Sleep Apnea     Other: \_\_\_\_\_

**Test Ordered:**

- Multi-night Sleep Study to rule out OSA (95806/GO399 *Test consists of: Pulse Oximetry, Heart Rate, Nasal Airflow, Respiratory Effort, and Body Position*)
- Titration study at home to test efficacy and pressure settings on auto-cpap/bi-pap (95806/GO399 *test consists of Pulse Oximetry, Heart Rate, Airflow, Respiratory Effort, Body Position, IPAP and EPAP settings*) Please list current cpap or bi-pap settings \_\_\_\_\_

**Post Test Instructions:**

- If CPAP therapy appropriate, my choice of HME provider is \_\_\_\_\_

**Referring Physician Demographics:** *\*( Fill out if first time referring only)*

Physician Name: \_\_\_\_\_ UPIN: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Physician's Printed Name:** \_\_\_\_\_

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I am the patients treating physician and I have filled out this prescription based upon a face to face office visit. I am ordering this test to determine if my pt has OSA.

\*\*\*Please fax this form along with patient demographics, Copy of Insurance card, and pertinent H&P to FAX # (800) 260-7001.

\*\*\*Failure to provide this information could delay patient testing. **THANK YOU!** (253) 853-1712 or 866-304-5630