U.S. Sleep Diagnostics
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Home Sleep Test Order Form

Patient Demographics:

Name: _____ Sex: _____ DOB: _____ SS#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Alternate Phone: _____ SUBSCRIBER ID# _____

ATTACH COPY OF INSURANCE CARD FRONT AND BACK

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

- ☐ **Sleep disordered breathing**
- ☐ **Excessive daytime somnolence**
- ☐ **Awakening gasping for breath**
- ☐ **Morning headaches**
- ☐ **Mood Disorders**
- ☐ **Loud snoring**
- ☐ **Observed apnea**
- ☐ **Non-restorative sleep**
- ☐ **Morning dry mouth**
- ☐ **Cognitive Impairment**
- ☐ **Insomnia**
- ☐ **Heart disease**
- ☐ **Arrhythmia**
- ☐ **Stroke**

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 ☐	1 ☐	2 ☐	3 ☐
2. Do you get sleepy, or doze off, while watching TV?	0 ☐	1 ☐	2 ☐	3 ☐
3. While sitting or inactive in a public place (meeting, Theater)?	0 ☐	1 ☐	2 ☐	3 ☐
4. As a passenger in a car for an hour without a break?	0 ☐	1 ☐	2 ☐	3 ☐
5. Lying down to rest in the afternoon?	0 ☐	1 ☐	2 ☐	3 ☐
6. Sitting and talking to someone?	0 ☐	1 ☐	2 ☐	3 ☐
7. Sitting quietly after lunch without alcohol?	0 ☐	1 ☐	2 ☐	3 ☐
8. In a car, while stopped for a few minutes at a traffic light?	0 ☐	1 ☐	2 ☐	3 ☐
		Total Score *(sum of all numbers checked above)* Scores ≥IO suggest patient is at high risk for Obstructive Sleep Apnea		

Suspected Diagnosis: *(one must be checked)*

☐ 327.23Obstructive Sleep Apnea ☐ 780.54 Hypersomnia ☐ 780.51 Insomnia/Sleep Apnea ☐ Other: _____

Test ordered:

☒ Multi-night Sleep Study to rule out OSA

Level III test consists of: Pulse Oximetry, Heart Rate, Nasal Airflow and Chest Movement

**Our Standard for Home Sleep Testing is the Level III test. We will however substitute a Level IV if we feel the pt cannot adjust chest belt on Level III test.*

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.

6822 93rd Street, CT NW, Gig Harbor, Wa 98332

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Phone: (866) 304-5630

FAX to: **(800) 260.7001**