

Local Home Health Provider

Phone: _____
Fax: _____

- Patient device pick up/drop off
- Partner device pick up/drop off
- Ship device to patient

Home Sleep Test Order Form

Prescription and Clinical Evaluation

Customer Support: (833) 32-SLEEP
(833) 327-5337

www.thesleepmd.com

1 Patient Information:

NAME		GENDER		DOB (mm/dd/yyyy)	
ADDRESS		CITY		STATE	
HOME PHONE		WORK PHONE		CELL PHONE	
PREFERRED WRITTEN LANGUAGE		PREFERRED SPOKEN LANGUAGE			
EMERGENCY CONTACT		EMERGENCY PHONE			

2 Insurance: Check here if self-pay

PRIMARY PAYER	ID #	GROUP #	PHONE
SECONDARY PAYER	ID #	GROUP #	PHONE

3 Prescriber Information:

NAME	ADDRESS	CITY / STATE / ZIP
PHONE	FAX	NPI
REFERRAL COORDINATOR	PHONE	EMAIL

4 Sleep History & Physical Exam: (Fill in the blanks and check all symptoms that apply)

Height: _____ inches Weight: _____ lbs BMI: _____ Neck Size: _____ inches Sleep Epworth Score: _____ (0-24)

<input type="checkbox"/> Sleep Disordered Breathing	<input type="checkbox"/> Loud Snoring	<input type="checkbox"/> Depression	<input type="checkbox"/> Insomnia
<input type="checkbox"/> Oral Appliance Assessment	<input type="checkbox"/> Non-Restorative Sleep	<input type="checkbox"/> Gasping / Choking	<input type="checkbox"/> Observed Apneas
<input type="checkbox"/> Excessive Daytime Sleepiness	<input type="checkbox"/> Morning Headaches	<input type="checkbox"/> Dry Mouth in A.M.	

5 Cardiopulmonary / Upper Airway Exam: (Check all that apply)

<input type="checkbox"/> Nasal Obstruction	<input type="checkbox"/> Over / Under Bite	<input type="checkbox"/> Crowded Oropharynx	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Teeth Worn	<input type="checkbox"/> Enlarged Tongue	<input type="checkbox"/> Enlarged Tonsils	<input type="checkbox"/> Retrognathia / Micrognathia
<input type="checkbox"/> Maxillomandibular Abnormalities	<input type="checkbox"/> Crowded Hypopharynx	<input type="checkbox"/> Obesity	

6 Diagnostic Codes: (Check all ICD-10 codes that apply)

G47.10 Hypersomnia, Unspecified G47.30 Sleep apnea, Unspecified G47.33 Obstructive sleep apnea (adult) (pediatric)

7 Home Sleep Test Procedure: 2-nights unattended, Portable Recorder with minimum four (4) channels, for example: Records airflow, respiratory effort, O₂ saturation and heart rate. Performed on room air unless specified below.

<input type="checkbox"/> Home Sleep Test Comprehensive Sleep Evaluation	<input type="checkbox"/> Home Sleep Test with Room Air	<input type="checkbox"/> Home Sleep Test with Oxygen LPM: _____	<input type="checkbox"/> Home Sleep Test with PAP PAP Pressure: _____ Fixed / Auto pressure	<input type="checkbox"/> Home Sleep Test with Oral Appliance	<input type="checkbox"/> Home Sleep Test with DOT certification	<input type="checkbox"/> Home Sleep Test for pediatric patient ages 2-17
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* Sleep Stages Testing procedure to be performed separately for 2-nights using EEG, EMG and EOG.

8 Prescriber Signature & Certification: (Stamped dates / signatures not valid. Must be signed by Prescriber / PA / NP)

I, the undersigned, certify that I am the patient's treating prescriber and that the information contained on this form is based on a face-to-face office visit. I am prescribing a two-night serial HST as medically necessary to validate results because of night to night variability.

Sign Here: _____ Date: _____

Please fax completed order form & insurance card to 1 (855) 448-9510