Home Sleep Test Order Form

U.S. Sleep Diagnostics

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)*

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

☐ G47.33Obstructive 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***