HST Order Notes

Patient Demographic / Dr. Prescription Form

Patient Name: ______________________________ DOB: ____________________

Address: ____ Phone: ________________________

Primary Insurance: _________________________________ Policy #: ____________________

Secondary Insurance: _______________________________ Policy #: ____________________

(please provide copies of patients insurance cards)

Home Sleep Test ordered due to suspected sleep apnea and medical history of:

Diagnostic Codes

- ☐ G47.33 Obstructive Sleep Apnea
- ☐ G47.10 Excessive Daytime Sleepiness
- ☐ R06.83 Snoring (Respiratory Abnormalities)
- ☐ G47.54 Parasomnias (sleep disorders)

- ☐ R53.83 Fatigue
- ☐ E66.9 Obesity
- ☐ E11.9 Diabetes Type II
- ☐ I10 Hypertension
- ☐ R35.1 Nocturia
- ☐ G47.30 Witnessed Apnea
- ☐ I67.89 Stroke
- ☐ I48.91 A-Fib
- ☐ I25.10 Coronary Artery Disease
- ☐ I50.9 Congestive Heart Failure
- ☐ R00.2 Heart Palpitations
- ☐ G25.81 Restless Leg Syndrome

- ☐ F33. Depression Recurrent
- ☐ R68.82 Decreased Libido

Ordering Physician: ________________________ Phone: ________________ Fax: ____________

Physician Signature: __________________________________ Date:____________________

Ordering Physician NPI: __________________

DME: DFW Sleep Solutions Dr. Suzanne Thai IAOS Phone: 940-498-2264 Fax: 940-498-2366

Additional Notes: