Sleep Lease

HST Order Form

PATIENT INFORMATION

Full Name: Date of Birth: Gender: ☐ M ☐ F

Address: City: State: Zip:

RM#:

Language (if not English): Height (ft): Weight (lbs): BMI:

Skilled Nursing Facility / Home

Requested Test Date

☐ Patient discharging in the next 48 hours

PHYSICIAN INFORMATION

Full Name: NPI:

Address: City: State: Zip:

Email: Phone: Fax:

DIAGNOSIS *(Choose 1 suspected Dx below)*

- ☐ **327.23 Obstructive Sleep Apnea**
- ☐ 780.53 Hypersomnia
- ☐ 780.51 Insomnia with Sleep Apnea
- ☐ 780.57 Other and Unspecified Sleep
- ☐ Other ICD-9:

SIGNS & SYMPTOMS *(Choose 2 boxes below)*

List at least two of the symptoms below observed / reported during the patient's visit that included Vital Signs, HEENT, Neurological and Cardio / Pulmonary assessment.

- ☐ Chronic Snoring
- ☐ Apneic Events
- ☐ Nocturia
- ☐ Morning Headaches
- ☐ Awaken with SOB
- ☐ Awaken w/ dry mouth
- ☐ Abrupt awakening during the night
- ☐ Difficulty staying asleep
- ☐ Excessive Daytime Sleepiness

TEST ORDERED:

☐ Home Sleep Test. Unattended Type III (Records Airflow, Respiratory Effort, Pulse, O2 Saturation) on room air Indicate _____ L/M flow rate if test to be done on Oxygen (Note:Sleep Lease Corp. does not provide Oxygen)

PHYSICIAN SIGN & DATE *(A stamped signature is not considered a valid order)*

I am ordering a Home Sleep Test for the patient listed above. I certify this patient was evaluated during an office visit and demonstrated signs and symptoms consistent with Obstructive Sleep Apnea that requires Home Sleep Testing for evaluation. I further attest the evaluation was documented in the patient's chart notes prior to ordering this test.

Physician Signature: Date:

PLEASE FAX THIS ORDER TO (888)-680-3008

Office (888)-657-6662